The Olmstead Plan in Arkansas




A Catalyst for Collaboration and Change

March 31, 2003

By

The Governor's Integrated Services Task Force

and

ARKANSAS DEPARTMENT OF HUMAN SERVICES

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March 31, 2003

Governor Mike Huckabee
The State Capitol, Room 250
Little Rock, Arkansas 72201

Dear Governor Huckabee:

In 2001, the *Olmstead* Working Group presented to you an initial report on how the State of Arkansas should respond to the U.S. Supreme Court's *Olmstead* Decision. You then authorized the creation of the Governor's Integrated Services Taskforce (GIST) to assist DHS in writing the State's "comprehensive, effectively working plan," as called for in the *Olmstead* Decision. Those appointed included a diverse group of consumers, advocates, providers, and state agency representatives. The GIST went on to create subcommittees for Public Awareness, Staffing, Finance, Supports and Services, Assessment, Access and Transition, and Quality Assurance.

Since July 2001, the GIST has held over a dozen full meetings and many more subcommittee meetings. This effort resulted in 114 recommendations, and I am pleased to report that some have already been accomplished, while work is underway on many others. Based on those recommendations, a draft *Olmstead* Plan was developed, first by a GIST Writing Committee and then by DHS staff. The draft was put out for public comment and presented at six public hearings in Springdale, Texarkana, Monticello, Jonesboro, and North Little Rock (2). The comments submitted were all considered and many have been addressed in this revised plan.

This plan is the culmination of much collaborative work. At the same time, its development highlights the fact that much work remains to be done. Accomplishing the *Olmstead* goals and principles will require ongoing effort and resources of Arkansas and her citizens.

DHS is pleased to have had the opportunity to participate in the formalization of The *Olmstead* Plan in Arkansas. We now look forward to continued progress with our many partners in ensuring that the elderly and persons with disabilities have real choices in their lives.

Sincerely,

Kurt Knickrehm, Director

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EXECUTIVE SUMMARY/INTRODUCTION

I was born in 1968, with cerebral palsy. My mobility and speech were both affected. When I was six years old, my mother made a life changing decision: she placed me in an institution to live. As I got older, my early teenage years were filled with thoughts of living in my own place. I was told over and over again that could not be an option. When I turned eighteen, I finally became my own guardian. I then moved into a group home. Eventually, I moved into my own apartment.

I now live and work in the community of my choice. I serve as a Governor's appointee on the Arkansas Governor's Developmental Disabilities Council. I also serve on the Partners for Inclusive Communities; Consumer Committee, as well as the Arkansas Can Do Committee. In addition to these positions, I provide training for staff who work with persons with disabilities.

*The **Olmstead** decision has made it possible for persons to have true choice in their lives, where they wish to live, to work and to play.*

Vicki B. Oxford

The word "*Olmstead*" may mean little to most Americans but the concept behind it may shape the future for millions of us. It refers to an historic 1999 U.S. Supreme Court decision, *Olmstead v. L.C.*[1], focused on giving people with disabilities opportunities to receive services in the community. This report, Arkansas' response to *Olmstead*, outlines a comprehensive, effectively working plan for making the opportunities a reality.

Assisting the elderly and people with disabilities to live in the least restrictive setting is not a new concept in Arkansas. Long before the *Olmstead* Decision, Arkansas began implementing innovative programs to give people the choice of remaining in their homes and communities rather than entering institutions. Optional Medicaid programs such as Home Health and Personal Care, and Medicaid waiver programs such as ElderChoices, have helped thousands of Arkansans avoid or delay institutionalization. More recently, Arkansas has greatly expanded its home and community-based Medicaid waiver for people with developmental disabilities, launched the nationally renowned Independent Choices program, and received a number of major federal grants to design new Olmstead-related programs.

However, much more needs to be done. Even today, many elderly and people with disabilities find it difficult to get timely and appropriate services in the community. Lack of funding, lack of community capacity, opposing special interests, and restrictive federal and state rules all contribute to the problem.

Background

In the *Olmstead* decision, the Supreme Court found that the State of Georgia had violated the Americans with Disabilities Act ("ADA") by keeping two women in a state institution when they could have been served in the community. The ADA prevents discrimination toward and promotes the integration of people with disabilities into their local communities. Even though the Court emphasized that nothing in the ADA

[1] *Olmstead v. L.C.,* 527U.S.581(1999)

supports terminating institutional care for those unable to handle community settings, the holding in the *Olmstead* case is that:

> "[s]tates are required to provide community-based treatment for persons with …disabilities when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with … disabilities."[2]

The Court directly stated that "Unjustified isolation . . . is properly regarded as discrimination based on disability."[3] It observed that:

(a) institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life, and
(b) confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.[4]

Olmstead is applicable not only to disabled persons living in psychiatric hospitals, nursing homes and other institutions, but also to disabled persons living in the community who are at risk of institutionalization. The Court suggested that a state could establish compliance with the Americans with Disabilities Act if it has

1) a comprehensive, effectively working plan for placing qualified people in less restrictive settings, and
2) a waiting list for community-based services that ensures people can receive services and be moved off the list at a reasonable pace.[5]

Following the decision, advocates conducted meetings across the state to discuss *Olmstead*. The U.S. Office of Civil Rights met with groups to provide guidance. An *Olmstead* Working Group was appointed to write an *Olmstead* Plan for Arkansas. However, due to the enormity of the task, no plan was produced at that time. The Group did produce a report that reviewed the system and made recommendations. Many of those recommendations have since been implemented.

Upon submission of the *Olmstead* Report, Governor Mike Huckabee authorized the Director of the Department of Human Services to appoint a Governor's Integrated Services Taskforce ("GIST") to assist DHS in writing an Olmstead Plan. The diverse group included consumers, advocates, providers, and representatives from a number of relevant state agencies.

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[2] Id. at 607.
[3] Id at 597.
[4] Id. at 600-601.
[5] Id. at 606.

Since July 2, 2001, the GIST has held over a dozen full meetings and many more subcommittee meetings. This work and the resulting recommendations provide the basis for the plan that follows.

Recommendations

I am 73 years old. I am living independently in the community again after leaving the nursing home where I lived for more than a year. Before moving into the nursing home, I had limited mobility and used a walker. Then, I broke my ankle. This left me unable to care for myself. My son felt I should be admitted to the nursing home. I remained there long after my ankle healed because there was no place for me to go. I had given up my home and all my furniture when I moved into the nursing home.

"Passages" is a nursing home transition grant from the Centers for Medicare and Medicaid Services. Through Passages, I was able to get the assistance I needed to have a chance to move back into the community. A transition coordinator helped me find an apartment. She used grant funds to buy me some new furniture and household necessities. I continue to receive assistance with my personal care and with home-delivered meals. I have now been living independently in my own community for over a year, and I am thriving.

Sylvia Warren

The GIST recommendations generally cover four needs: additional resources, community capacity, new approaches to service provision, and better information for consumers.

Some recommendations call for significant new resources. In particular, additional funding is needed to strengthen the mental health system and to serve people on the Developmental Disabilities waiver waiting list. Many other recommendations will require some funding, but the amount is, as yet, undetermined or it is expected that some new costs can be covered via savings in existing services.

Of at least equal importance to funding is the need to develop additional community capacity to serve people with disabilities. While some local providers offer a wide array of services and have many clients with complex needs, others have little or no ability to serve such clients. Funding limitations, shortages of qualified staff, hesitation to take on new ventures, and fear of liability all contribute to the problem. Regardless of the reasons, the result is that many consumers face long delays and limited choices in receiving community-based care. Some also are quite concerned about the stability and continuity of care once it is available.

Addressing these capacity issues will require some new funding to cover the cost of more complex plans of care. However, creativity and new approaches to care will also be needed. Finding better ways to attract and retain caregivers, revising policies and programs to speed up access to care, and encouraging existing and new providers to meet the specific needs and desires of more challenging clients are all essential.

One approach that appears especially promising is to give consumers more control over what services they receive and who provides them. Arkansas' Independent Choices

program, an example of such “consumer-directed care”, has been a national model for people needing personal assistance and this plan calls for similar efforts in other areas.

Finally, the report calls for much-improved consumer information on what services are available and how to access them. Far too often consumers are unaware of their options, causing them to prematurely or unnecessarily enter institutions or to receive inadequate community-based care. Better information will lead to better care, and often at a lower cost.

Altogether, the GIST developed 115 recommendations covering a wide variety of topics. Some recommendations support ongoing efforts, while others call for entirely new actions. Of these 115, the GIST identified ten priorities. They are:

1. Clarify the Nurse Practice Act to encourage flexibility in caregiving, while ensuring quality.

2. Restructure mental health service delivery to better utilize current resources and enhance access to care.

3. Develop a website listing consumer services.

4. Use existing housing funds to finance integrated housing community facilities.

5. Provide information to applicants about alternatives to institutionalization.

6. Facilitate transitions from institutional settings to the community.

7. Reduce waiting lists for home and community waivers.

8. Reduce the response times for obtaining home and community waiver.

9. Increase consumer direction for waiver and state plan services.

10. Advocate for mental health insurance parity.

The Plan

While focusing on those ten priorities, this plan calls for thirty initiatives that address forty-nine of the recommendations. It sets out action steps for each one, identifying the lead entity, anticipated funding requirements and the anticipated completion date.

Some of the highlights of the plan include:

1. Major changes to the State’s mental health care system, including $5.8 million annually in new funding to implement the changes.

2. Quicker access to home and community-based care services, including approximately $20 million in new funding for the Developmental Disabilities Medicaid waiver.
3. Assessing all individuals seeking to enter an institution to determine eligibility and fully inform them of their community options.
4. Allowing money to follow the client. With the support of federal State Innovation Grants, Arkansas will allow some Medicaid beneficiaries who live in nursing homes an option to receive a cash allowance to live in their own homes and will pilot a self-direction initiative for persons with development disabilities.

Ideally, all recommendations would be engaged immediately. In fact, some state *Olmstead* plans read as if all goals should and could be addressed at once, calling for huge sums of funding and assuming that state and local entities have the capacity to implement major expansions immediately.

Although such plans sound bold and may, on paper, address every desire, they are seldom realistic and often result in more frustration that actual change. Plans that States cannot implement because of budget constraints create no progress toward achieving *Olmstead* objectives. State budgets are limited. Good policy and programs take time to develop and acquire legislative and federal approval, and demands on community providers to change and expand rapidly often come at the expense of quality.

This plan calls for aggressive, but realistic progress, with the understanding that additional initiatives will be undertaken as resources and capacity are available.

> *I am now in my early twenties. I have spent most of my life in treatment facilities since I was 13, including a two-year stint in the Arkansas State Hospital. During that time, I managed to become one of the best known names because of my extreme behavioral and management problems. I engaged in persistent self-mutilation.*
>
> *Since October, 1997, Arkansas State Hospital and Birch Tree Communities have cooperated in my treatment. The focus has been on keeping institutionalization to a minimum. Various treatment team configurations and housing arrangements have been employed. My last inpatient admission was August 2000. I have not self-mutilated since then. Although I require intensive case management to assist me, I have been living independently for more than a year and I have a part-time job. Because my psycotropic medications have been reduced, I am now happy and am able to engage other people in satisfying ways.*
>
> *KB*

Next Steps

Work has already begun on many recommendations. Arkansas recently received a number of grants to support systems-change efforts, including improving consumer information, establishing consumer-directed programs and assisting individuals moving from institutions to the community. These initiatives are all underway.

The Governor's Supported Housing Task Force, whose report augments this one, continues to meet and progress toward the goal of providing housing for people transitioning from institutional settings.

Governor Huckabee's budget plan for the 2003 Legislative Session includes full funding of the DHS requests for the mental health system and the developmental disabilities waiver. These plans now require legislative support, as will any proposed activity on mental health parity, and revisions to the mental health commitment laws and the Nurse Practices Act.

To ensure continuing attention to, and guidance on *Olmstead*–related challenges, DHS will request authorization from the Governor to continue the GIST for one additional year. This body will bring a sense of organization and management to the overall goals of this initiative. They can continue to work on the recommendations not specifically addressed in this plan. They can advise the State. They can contribute to any necessary modifications in the plan. They will serve as a continuing forum to discuss the dramatic changes in perspective about services for persons with disabilities that are occurring, and initiatives that can build on this plan. The collaboration, synergy and coordination of this ongoing group will contribute greatly to the ultimate successes of *Olmstead* implementation.

Finally, because DHS is home to Medicaid and some agencies serving people with disabilities, it is, at times, seen as the responsible party for Olmstead. However, it is clear that success depends on far more than just DHS. One state agency neither can nor should have responsibility for such fundamental change. Community providers, consumers and families, advocates, other state agencies, and the federal government are all key players.

More than anything, though, success of this effort is dependent on local communities and individual citizens. Olmstead is not about closing institutions, as some have feared. However, it is about giving people with disabilities the opportunity to live in the community. State and federal government can create programs that support community-based options. But those options will only be real if local communities welcome people with disabilities and the strengths and challenges they bring with them.

The collaboration and hard work of many individuals over the last several years has sparked remarkable progress in serving people with disabilities. This synergy can continue. The plan lays out a realistic, ambitious blueprint to assure that progress as well as the State's compliance with the *Olmstead* decision. However, the hope is to go beyond the legal standards to give Arkansans a choice of health and human service options that respond to their individual needs.

> *I was born in 1979 with Cerebral Palsy. My speech and mobility are affected. As a child, I required total care in all areas. I thrived at home. I would work so hard to accomplish the smallest tasks. When I was 14 years old, my family and I had my first transition plan with the school to decide what type of supports and services I would need when I graduated from high school. My family and I entered the conference with high hopes and expectations, only to be told that under the current system in Arkansas,*

the only option for me was either a nursing home or an institution.

Now I am 23 years old. Even though I still require total assistance to participate in my community, I am doing it. The supports and services provided under the Arkansas Home and Community Based Waiver provide the support I need to be a participant in the community of my choice.

The Olmstead decision states that people with disabilities must have choice in where they wish to live, regardless of the setting.

Erik D. Riggs

BASELINE DATA

In order to develop a comprehensive and effective *Olmstead* Plan for Arkansans with disabilities, it is first necessary to understand the context of services and programs available at the present time. The following charts* set out useful data to establish the current baseline. When possible, the charts present data for the past five years to demonstrate the trends that have developed. The data shows that the use of nursing homes and Human Development Centers has declined from SFY98 to SFY02.

The age 65 and older population account for the largest number of long term care users. Use of institutions by aging people peaked in 1992, the year the Elder Choices waiver began. Since 1998, the number of Medicaid recipients has declined almost 11%. Even so, nursing home expenditures have grown from $269,199,067in SFY98 to $368,316,025 in SFY02. There was an average of 12,898 Medicaid recipients in nursing homes on any given day. The average cost of their care was $28,355 per Medicaid bed per year.

Likewise, the number of individuals in HDCs has declined over the last 5 years, from 1,244 in 1998 to 1,161 in 2002 (June 30 Midnight Census). At the same time, the cost of their care rose from $81,589,853 to $84,508,060, making an average cost of $72,789 per Medicaid bed per year. Individuals with developmental disabilities use more services per capita.

New ways to deliver care emerged through waiver services. Arkansans have responded to these services dramatically. While the data demonstrates the use of nursing homes and HDCs has declined, the use of home and community-based waivers has expanded significantly.

Waiver	1998 Expenditures	2002 Expenditures
DDS	$17.6 Million	$64.8 Million
Elder Choices	23.7 Million	33.0 Million
Alternatives	1.0 Million	11.0 Million
Total	**$42.3 Million**	**$109.2 Million**

For the DDS waiver, there were 3,423 unduplicated beneficiaries with an average cost of $18,924 per person. For the ElderChoices Medicaid Waiver, there were 8,102 unduplicated beneficiaries with an average cost of $4,075 per person.

In addition to these waivers, IndependentChoices gives those age 18 and over the opportunity to self-direct their care. In SFY02, 1,582 consumers managed over $5 million of care.

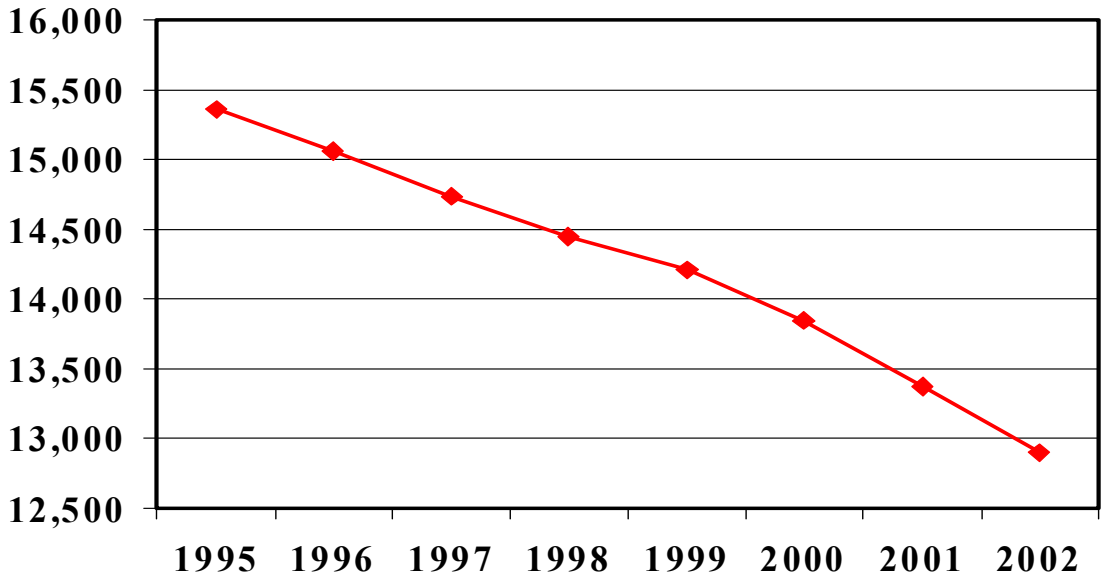
Another dramatic increase in spending occurred in Mental Health services. It rose from $121.9 million in SFY98 to $192.7 in SFY02. Also, DDTCS expenditures grew from $42.4 million to $62.1 million during the same period.

*The charts may be found in Appendix A.

Chart One

Medicaid Recipients in AR Nursing Homes

(June 30 Census)



Excludes AR Health Care Center, ICF-MRs & Pediatric Homes

THE CATALYST COMPONENT

A plan to insure that individuals with disabilities have a choice about where they receive services could have been written by state agency staff who were familiar with budgets and programs. Likewise, the plan could have been written by consumers, parents and advocates who understand firsthand the impact that budgets and programs have on a person's life. However, a better solution was to join forces and collaborate to create a plan that would be better than either plan would have been on its own.

Following the initial work of the *Olmstead* Work Group in 2000, the Department of Human Services ("DHS") submitted in February, 2001, a thirty-page report to the Governor, which noted these seven initial recommendations for Arkansas:

1. Review current systems to identify opportunities for change
2. Adequately fund the Division of Developmental Disabilities Services ("DDS") Home and Community-Based Services under the Medicaid Waiver and monitor all waiver service quality
3. Pilot and develop an assessment process to evaluate consumers' choice of care setting
4. Develop teams to assist individuals who desire a transition to other service settings
5. Appoint and convene an on-going advisory group for Olmstead implementation
6. Reconvene a Supported Housing Taskforce, and
7. Apply for a federal Real Choice Systems Change grant[6]

Work on the initial recommendations began immediately and has been on going. Progress includes:

Recommendations #1 and #7: Arkansas applied for and received not one but three Systems Change grants from President Bush's New Freedom Initiative, for a total of $3,205,001.00 in grant funding. This does not include the grants from other sources that DHS has been awarded. State agencies reviewed their current systems for the grant application process. Consultation purchased from grant funding will provide further review, pilots, and recommendations for best practice for real systems change.

- Division of Aging and Adult Services ("DAAS") sought and received a competitively awarded **Real Choice Systems Change grant** from Centers for Medicare/Medicaid Services ("CMS"). The goal of this three-year grant is to produce changes in Arkansas' service system to give individuals more choices in how and where they receive long term care. The grant was developed with the assistance of a Real Choice Advisory Committee of consumers and advocates.

- DHS/ Division of Developmental Disabilities Services ("DDS") competitively sought and received the largest **Community-Integrated Personal Assistance Services and Supports Grant (PASS Grant)** in the nation. The **PASS grant** will promote the concepts of independence, self-determination, and consumer control to design a more flexible and responsive system for people with disabilities. An Advisory Council of parents, consumers,

[6] Arkansas Department of Human Services, *The Report of the Olmstead Working Group,* February 15, 2001, p. ix-xiii.

providers, advocates, and legislative and executive branch representatives oversee activities of the grant.

- DAAS was awarded a $500,000 **Nursing Home Transition Grant**, Passages, to help individuals living in institutions move back into the community. DAAS has recently been awarded a **second Nursing Home Transition Grant** for $598,444.

- DDS competitively sought and received a **Family Support grant for $200,000** to provide systems change for the Division's Family Support program.

Recommendation #2: DDS continues to add consumers to its waiver. DDS has historically released approximately 50 names per month for processing, although that has been curtailed in recent months because of state budget shortfalls. See Baseline Data in the Appendix for increase in people served and the increase in expenditures in the last two fiscal years.

Recommendation #3: Contracting has been completed for the assessment of a 300 person sample of individuals in nursing homes and Intermediate Care Facilities for Mental Retardation (ICF/MR). The volunteer assessors have been selected and trained. They will be provided with the final details of the assessment process in February, 2003, with the actual assessments beginning in March. The Pilot managers will assess their progress and evaluate data in April. The goal is for assessments to be completed in June, 2003. Based on the results of this pilot, decisions will be made on the best way to proceed with further assessments.

Recommendation #4: Two mechanisms are in place to address transitions from institutions. The Passages I grant is funding transitional costs for persons leaving nursing homes. Passages II will continue this and add persons transitioning from Intermediate Care Facility for the Mentally Retarded ("ICF/MR"). A pilot project is underway at the Alexander Human Development Center (ICF/MR) that is designed to improve a person's chances for a successful transition through an overlay of services. The Center has secured funding for the transition costs of one individual. DDS has been awarded $50,000 in federal grant funding to enhance this effort. DDS has also collaborated with a provider on another federal grant to support better employment of individuals who transition from ICF/MR.

Recommendation #5: The Governor's Integrated Services Taskforce ("GIST") was authorized by the governor and convened for its first meeting July 2, 2001. Subcommittees were formed to work on topic areas and to make recommendations to DHS.

Recommendation #6: The Governor's Task Force on Supported Housing submitted its report to Governor Huckabee on June 6, 2002. The report recommends utilizing both existing housing and creating new housing stock for persons with disabilities. Interestingly, the report focused on housing as an economic and not simply a disability issue.

Even with all this progress on the *Olmstead Report* recommendations, much work remained. The GIST subcommittees formulated 115 new recommendations, which were approved by the full Taskforce on May 28, 2002. DHS staff were assigned to work with GIST members on a writing committee to evaluate how the recommendations could be incorporated into a "comprehensive and effectively working"[7] plan. After several months of work, the GIST selected its top ten recommendations and voted to assign the work of writing the final plan to DHS.

[7] *Olmstead,* at 606.

THE GIST PRIORITY RECOMMENDATIONS

After meeting for several months, the GIST Writing Committee asked the GIST to vote for ten priority recommendations to establish some areas of emphasis in writing the Arkansas *Olmstead* Plan. These are the ten priority recommendations of the GIST:

1. **Address issues related to the Nurse Practice Act.** GIST Recommendation #18. For further discussion, see page 14.

2. **Restructure mental health service delivery**. GIST Recommendation #4. For further discussion, see page 18.

3. **Develop a website listing consumer services.** GIST Recommendation #91. For further discussion, see page 16.

4. **Use existing housing funds to finance integrated housing community facilities.** GIST Recommendation #5. For further discussion, see page 28.

5. **Provide information to applicants about alternatives to institutionalization.** GIST Recommendation #7. For further discussion, see page 15.

6. **Facilitate transitions from institutional settings to the community.** GIST Recommendation #9. For further discussion, see page 21.

7. **Reduce waiting lists for home and community waivers.** GIST Recommendation #12. For further discussion, see page 14.

8. **Reduce the response times for obtaining home and community waiver.** GIST Recommendation #20. For further discussion, see page 15.

9. **Increase consumer direction for waiver and State Plan services.** GIST Recommendation #22. For further discussion, see page 23.

10. **Advocate for mental health parity for health insurance.** GIST Recommendation #49. For further discussion, see page 14.

Even though these ten recommendations are ranked as priorities by the GIST, DHS considered all of the114 GIST recommendations. They are all incorporated by reference.[8] Most of them are incorporated into the body of the plan. The priority recommendations gave the DHS writing staff a systematic way to address the recommendations. In addition, because of the cooperation that developed among the GIST members over the course of their work together, the State felt that emphasizing the ten GIST priorities would contribute to the evolving collaboration. These recommendations, then, have served as the building blocks for the development and implementation of an effective, comprehensive *Olmstead* plan for Arkansas.

[8] See Appendix B.

To capitalize on this collaboration, **DHS will request authorization from the Governor to continue the GIST [9] for one additional year and retain a majority of its current members.** In addition, DHS will request representatives from the Department of Education and other groups to join the GIST. This body will bring a sense of organization and management to the overall goals of this initiative. They can continue to work on the recommendations not specifically addressed in this plan. They can advise the State. They can contribute to any necessary modifications in the plan. They will serve as a continuing forum to discuss the dramatic changes in perspective about services for persons with disabilities that are occurring. The collaboration, synergy and coordination of this ongoing group will contribute greatly to the ultimate successes of *Olmstead* implementation.

The work of these various groups and constituencies over the last several years has sparked a remarkable catalyst toward accomplishing *Olmstead* objectives. This synergy can continue. The plan lays out a realistic, ambitious blueprint to assure that progress as well as the State's compliance with the *Olmstead* decision. However, the hope is to go beyond the legal standards to give Arkansans a choice of health and human service options that respond to their individual needs.

[9] GIST Recommendation #114.

THE COLLABORATION COMPONENT

ACCESS TO SERVICES

People with disabilities encounter obstacles as they seek services. The following recommendations address many of those obstacles.

PRIORITY RECOMMENDATION: Address issues related to the Nurse Practice Act.

An example of the potential of a collaborative effort for the GIST can be found in the GIST Recommendation to address issues related to the Nurse Practice Act.[10] The GIST believes that the Arkansas Nurse Practice Act needs to be amended to better support the provision of long term care services in home and community settings. For example, the Act could be amended to provide registered nurses protection from liability so that they can be allowed to delegate the authority for the administration of medications to trained paraprofessionals. This can be accomplished by utilizing the model developed in Tennessee that incorporates training and licensing of CNAs for delivery of specific personal care services to relieve the workload of registered nurses and protect them from liability. This will require legislation. DHS will facilitate the formation of a workgroup composed of the State Board of Nursing, DHS, the Arkansas Department of Health ("ADH"), and the GIST to review the Nurse Practice Act and draft legislation accordingly**.**

PRIORITY RECOMMENDATION: Advocate for mental health parity for health insurance.

This is also a priority recommendation of the Governor's Mental Health Task Force. Mental illness is just as real and as debilitating as physical illness. Yet, most private insurance provides very little coverage for mental health when compared to physical health. Higher co-pays and deductibles and much lower annual and lifetime limits are the norm. Different forms of mental health parity have been implemented around the country, and opinions vary on parity's impact on health insurance premiums. The state should work to implement parity while minimizing the possibility of it resulting in increasing numbers of uninsured.

PRIORITY RECOMMENDATION: Reduce waiting lists for home and community waivers.

Funding and community capacity for services are the two greatest barriers to moving individuals onto the Developmental Disabilities waiver for home and community based services[11]. While DDS continues to add consumers to its waiver, state revenue shortfalls have slowed the pace considerably from the usual fifty per month. DDS is requesting $6.4 million in new state funding for the waiver in the next biennium. With

[10] GIST Recommendations #18 and #104.
[11] GIST Recommendations #12 and #15.

federal matching funds, this will increase waiver spending by approximately $20 million, serving an additional 1200 waiver clients and bringing the total of waiver clients to 3,067, the maximum currently allowed.

A major concern related to community capacity is the current daily maximum waiver payment rate of $160. Many consumers and providers have noted that the maximum rate has not changed for many years and that some clients cannot adequately be served with that funding cap. Therefore, in addition to requesting new waiver funding, DHS will review options for raising the daily maximum where it is warranted. Such a change, which must be approved by the federal government, is likely to occur following a formal rate study aimed at ensuring that payments for specific services are appropriate. That rate study is now underway.

PRIORITY RECOMMENDATION: Reduce the response times for obtaining home and community waiver

Reducing the response times for obtaining community services is another GIST priority. A Real Choice grant effort will, **through a "fast-track" process[12],** reduce the eligibility wait time for DAAS Waivers. Consumers will have quick entry, timely eligibility determination, and consistent medical eligibility criteria, and access to services. Further objectives are to develop effective outreach material to educate community resource staff about the options to institutionalization, and to complete the Medicaid waiver application process within seven (7) days by establishing a centralized unit to process applications of individuals in jeopardy of nursing home placement. DDS already has in place a streamlined process to fast-track eligibility determination when processing applications for services.

ELIGIBILITY, ASSESSMENT, AND CHOICE

The State is committed to developing a broad, comprehensive long term care application process that assimilates three crucial *Olmstead* principles:

- a streamlined eligibility process;
- an assessment by professionals that includes a functional assessment, a medical assessment, and a choice assessment; and
- a broad-based informational component to ensure the applicant's choice.

Independent, objective professionals will perform all of these functions. The vision for this overall process is a dramatic departure from the application procedures that state government has offered applicants in the past. At times, applicants have had to go to a myriad of agencies, facilities, and offices, each with a different process and different criteria. It has been one of the chief complaints discussed by GIST consumers and advocates. Under the proposed process, this initiative will provide an entry into the system that should prevent many of the problems consumers currently encounter, causing them less frustration and providing care in the least restrictive setting.

PRIORITY RECOMMENDATION: Provide information to applicants about alternatives to institutionalization and the range of service options.

[12] GIST Recommendation #20.

A priority of the GIST is to provide information to applicants about alternatives to institutionalization[13]. Today, many people may enter institutional care because they are unaware of the home and community-based options available to them. And once in an institution, it is often difficult to return to the community. Therefore, it is essential to ensure that consumers are aware of their options ahead of time. The application/assessment procedure just outlined will meet this issue. **All applicants, both privately [14] and publicly funded, to a nursing home or Intermediate Care Facilities for Mental Retardation ("ICF/MR") will receive a face-to-face screening by an objective, independent entity prior to entry into an institution.** This initiative will likely be built on Maine's successful model, whereby every institutional applicant is visited by a registered nurse who assesses their medical condition, explains any available home or community based options to meet their needs, and explains the financial impact of the options. Applicants are then free to select whatever option best suits them. When combined with the "fast-track" application process described above, consumers will finally have a real choice.

A number of existing and planned actions will support this initiative. The 2002 Nursing Facilities Transition Grant will develop a working model for a diversionary process from nursing facilities for those already institutionalized. The grass roots effort will be established to meet with individuals and family members, hospital discharge planners, community social workers, nursing facility personnel, civic organizations, and advocacy groups to provide information about alternatives to institutionalized care. The Real Choice Grant and the Nursing Facilities transition grant will collaborate to develop effective outreach material to apprise individuals of the options for community living.

In another of these initiatives**, DHS has underway a pilot assessment of currently institutionalized individuals[15].** DHS has contracted with a nationally recognized accreditation organization, The Council on Quality and Leadership, which has completed the training for the volunteer assessors. After training was completed in October, these individuals will begin interviewing in March, 2003, a randomly selected sample of over 300 individuals living in Arkansas' nursing homes and ICF/MR. These interviews will have a two-fold purpose. First, they will identify specific individuals residing in care facilities that choose to and could benefit from a transition to the community. With the individual's permission, the interviewers will contact facility and other professionals who can identify needed services and assist the individual in making such a transition.

Secondly, these sample figures can be extrapolated to the entire institutional population to determine if there is a statistically significant percentage of institutional residents who would choose to live in the community. This will help to determine if funding, staff, and a process for 100% assessment of institutional residents would be cost effective. Data gained for the assessments will also help DHS and its contracted providers to plan both the types of community services and the capacity that must be built into the service delivery system for persons with disabilities.

PRIORITY RECOMMENDATION: Develop a website listing consumer services.

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[13] GIST Recommendation #7.
[14] GIST Recommendation #99.
[15] GIST Recommendation #8.

In keeping with a priority of the GIST, this initiative addresses the development of a website listing consumer services[16]. The three DHS Systems Change grants will collaborate to develop a website that lists available services for persons of all ages with disabilities and for seniors. Information on the array of services will be listed on the site, as will a toll-free number for questions and concerns. **A DHS Services Directory is already in circulation and a DDS directory will be completed in conjunction with the PASS grant that will correlate with information on the website for people with developmental disabilities . These will be coordinated and incorporated into the website[17].**

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In addition to these initiatives, the directories and website will be available to serve as part of the informational component of the application process. DHS can make the website available at a terminal in its county offices as well as make it accessible electronically through the internet. Therefore, those interested persons who have access to a computer will be able to access the Directory of Services as needed. DHS will develop a procedure for those agencies, facilities, and service providers that desire to be included in the website. To enable those individuals who do not have computer access and who are unable to travel to a DHS office, **DHS plans to offer a toll-free phone number through which affected individuals can obtain the same information about service providers in their area that is available on the web[18].**

These recommendations represent important objectives that demonstrate the movement toward better access to services that *Olmstead* is causing. With an independent application process, an independent professional assessment, **a comprehensive informational component**[19], a telephone information system, and a diversionary process, each person and/or their guardian will be prepared to make the best decision for themselves and for their family.

[16] GIST Recommendations #91 and #92.
[17] GIST Recommendation #93.
[18] GIST Recommendation #94.
[19] GIST Recommendation #13.

PROVISION OF SERVICES

As the authorized individuals assembled to address the GIST Recommendations, it became clear that there is a broad base of services upon which to build a comprehensive plan. While there remain gaps in the service system, it is nevertheless apparent that with better coordination, service delivery will be enhanced. As outlined in this section, DHS is working hard at this time to fulfill four objectives expressed by the GIST:

- restructure mental health services delivery;
- facilitate transitions from the institution to the community;
- reduce institutional bias; and,
- increase consumer direction of services.

MENTAL HEALTH SERVICES

GIST PRIORITY RECOMMENDATION: Restructure Mental Health Service Delivery[20]

Because the system of mental health services is in the process of major reformation, its service programs and the plans for changing them are addressed primarily in this section rather than blended throughout the Arkansas *Olmstead* Plan. Arkansas is not alone in its crisis of mental health services. Many of the same challenges are faced by most states in the U.S. Many of the funds spent on public mental health services in Arkansas are used for very expensive inpatient psychiatric care for a relatively small number of people. There is general consensus that if less intensive, less expensive settings were available, many of these patients could be effectively treated there[21]. Instead, many preventable and treatable emotional and behavioral problems are left unattended, causing deterioration, because the mental health system is inadequate in range, availability, appropriateness of services, trained personnel, and funding.[22]

The State staff understands there are no simple solutions. The public mental health system is being evaluated to address management issues, funding issues, and to find new approaches to both financing mechanisms and provision of services, as expeditiously as possible.[23]

From August, 2001 through May, 2002, the Governor's Mental Health System Taskforce met to address these fundamental issues. It was composed of sixteen Arkansans: mental health professionals, educators, administrators, judges, consumers and their families and advocates. Administrative staff of the Division of Mental Health Services served as resource persons to the Task Force as well as their work groups. They came together with a common concern for the health and well being of those who suffer from

[20] GIST Recommendation #4.
[21] Governor's Mental Health System Task Force, *The State of the State's Public Mental Health System,* June, 2002, p.1.
[22] Id., p.2.
[23] Id.

frequently misunderstood and stigmatizing labels of mental illness or emotional disturbance[24].

The Task Force had six areas of recommendations:

I. That the Division of Mental Health Services be empowered to make and implement mental health policy;
II. That all statutes, policies, and regulations promulgated by DMHS be reviewed and updated to assure uniformity of availability, accessibility, and quality of publicly supported community-based mental health services;
III. That the Governor and the Director of Human Services strongly encourage the General Assembly to
1) require mental health parity for private health insurance plans;
2) provide for local indigent psychiatric inpatient care as well as legislation to support local alternatives to hospitalization;
3) update current commitment laws; and
4) review and modify the single point of entry system for admission to Arkansas State Hospital;
IV. That potential modifications to the service plan and waivers be aggressively pursued to assure Medicaid reimbursement.
V. That the roles, target populations, and admission/discharge policies be reevaluated to assure cost-effectiveness, appropriate utilization, and equitable access;
VI. That measures be taken to ensure the availability of well-trained, stable, diverse and competent mental health professionals and paraprofessionals.[25]

In response to the Task Force Recommendations, DMHS has targeted six areas. They are funding for adult inpatient acute care, shifting funds to children's outpatient services, improving forensic services, working on commitment laws and parity issues, improving standards and accountability at ASH and Arkansas Health Center, and working on diversity issues. Not all of the recommendations or DHS responses pertain to *Olmstead* planning. The DMHS plans affected by *Olmstead* include:

1. DMHS is requesting $5.8 million in additional GR funds. The plan would put the CMHCs at risk or responsible for paying for the inpatient care of anyone whose income is below 200% of poverty. This system strongly encourages CMHCs to carefully evaluate the actual need for inpatient care, to provide assertive continuing care to reduce the risk of decompensation, to provide alternatives to hospitalization, and to perform effective discharge planning. With a bias in place for short-term acute care, the CMHCs could then use the additional funds plus any savings for crisis units, direct crisis intervention, crisis stabilization, and assertive community treatment.

2. In order to reduce the expenditures on inpatient services for children and redirect the money to outpatient services, DMHS is working with Medicaid on a

[24] Id., p.4.
[25] Id., pp. 6-12.

proposal for a single point of entry for all inpatient services through the CMHCs, working further with Medicaid on prior authorization for children's services, and working with DCFS on ensuring that children in foster care are receiving appropriate mental health services.

3. Improved forensic service delivery intersects with *Olmstead* because people with mental illness are vulnerable to being charged with crimes. If they can receive treatment without charges being brought against them, it will prevent them from entering the forensic system.

4. Concerning parity for mental health insurance, people with mental illness should have the same access to treatment that people with other physical illnesses have. If the availability of adequate mental health treatment is going to be ensured, there must be insurance coverage for appropriate treatment. The State should not be expected to be able to pay for all needed mental health treatment.

5. Regarding standards and accountability, the plan includes working with CMHCs and other DMHS facilities to expand and validate data collection, review CMHC contracts to add more specific requirements to performance indicators, establish benchmarks on critical indicators, revise CMHC standards, reestablish the site visits to CMHCs and the development of a state-wide consumer satisfaction survey.

DMHS is also currently working with Medicaid to draw down federal dollars to explore the development of community-based waivers. The objective is to use general revenue funds currently going to CMHCs as match for additional federal funds to increase the availability of community-based services. This would create additional money for CMHCs as well as additional funds for specific new mental health services. This effort is in the preliminary stages, and is being explored as an avenue to increase funds for mental health. The major barrier is whether budget neutrality regarding waivers can be established satisfactorily.

Advocates in the mental health field are acutely aware of the difficulty families and consumers face in obtaining alternatives to institutionalization. Currently, institutions such as inpatient hospitals, jails and residential care facilities are accessed by public mental health system providers to support much of the backbone for ancillary needs. As an alternative, organizations are advocating for additional programs such as Crisis Stabilization Centers, Assertive Community Treatment teams (to provide wraparound services), and Crisis Intervention Teams (to promote jail diversion). A pilot CIT project is to establish a crisis intervention team in the Little Rock area in partnership with the Little Rock Police Department, University of Arkansas Medical Sciences (UAMS), National Association for Mental Illness (NAMI), and the Little Rock CMHC. This program allows the police to divert persons that they feel may have a mental illness into a crisis stabilization program rather than having to place them in jail. The program has been very successful in the few months it has been in operation. DMHS hopes to establish more of these programs throughout the state. With the goal of additional crisis centers and replication of additional ACT and CIT programs, the number of alternatives to institutionalization will substantially increase.

TRANSITION FROM INSTITUTIONS

PRIORITY RECOMMENDATION: Facilitate transitions from institutional settings to the community.[26]

The GIST sixth ranked priority recommendation was for DHS to identify and facilitate transitions from the Human Development Centers for those who choose to live elsewhere while guaranteeing a return to the HDC if a transition was not successful. There already exists a 30 day window for a return to an HDC to provide a "safety net" to a person in a new service setting. Several clients of the HDCs will be assessed as part of the random sample in the pilot assessment. If a 100% institutional assessment is deemed feasible by the pilot, the rest of the clients will be assessed as well.

Other innovative ideas are also already in progress. The Alexander HDC is piloting a new transition mode, and secured grant funding from the Developmental Disabilities Council for the transition of one individual. The Center may also use DAAS Passages transition funding and ADFA bridge rent subsidies. The Jonesboro HDC is investigating the creation of a partnership with a community provider for a crisis center on campus. Arkadelphia HDC offers dental and neurological services to persons living in the community, offers training to community providers, and is collaborating to start a new People First chapter in the southwest corner of the state. The Conway HDC has applied for a grant to build a vocational training center on campus to offer vocational training and opportunities to any individual with a disability and eventually to workers living in the community during the last fiscal year, and utilized the services of community educators, therapists, and medical personnel, as well as other DHS professionals. The Conway HDC also works with Faulkner County Council on Developmental Disabilities to provide supported employment.

In a related service, DMHS coordinates with CMHCs when a patient is discharged from ASH. Discharge planning tasks such as making appropriate appointments are completed to ensure that the necessary services for the patient will be available upon their return to the community.

Transitioning from an institution requires assistance and funding. The DAAS' grant project for nursing home transitions, Passages I, assists individuals who wish to leave a nursing home to live in the community. An individual is assessed to determine whether his/her needs can be successfully met with services available in the community. Support services assist in making the move to the community and may include housing, rent and utility deposits, furniture, household goods, temporary personal and attendant care. This type of supportive transition process was one of the recommendations of the Governor's Supported Housing Task Force. Therefore, Passages I is meeting that recommendation as well.

The 2002 Nursing Facilities Transition Grant managed by DAAS will have a Community Bridge Fund that will help pay for items that are necessary for an individual to return to the community and will include residents of ICF/MR. **The fund may cover the cost of rent, deposits, household furnishings and goods, or support services on a**

[26] GIST Recommendations #9, and #10.

temporary basis such as personal or attendant care, meals on wheels, and personal response systems. CMMS has approved waiver services to cover transition costs. DAAS will amend the 1915(c) waivers to include this service before these grant funds are exhausted[27].

The pilot assessment project mentioned in the previous section entitled "Access to Services" will also enhance the transition of individuals from institutions to the community. As the assessments progress, understanding the issues and how they emotionally impact institutionalized individuals will help determine the direction of services offered.

DIVERSION FROM INSTITUTIONS

A major concern of the GIST was that the system makes it easier for a person to enter an institution than to receive services in the community[28]. Too often, when a person experiences an acute illness, injury, or behavioral episode, admission to an institution is the initial solution. Once a person has made the necessary lifestyle changes to enter an institution, he or she may find that it is more difficult to return home than it would have been to remain in the community in the first place. Many supposed "short term" stays in a nursing home or an Intermediate Care Facility for Mental Retardation (ICF/MR) become extended stays that last a lifetime.

DHS is recognizing and is addressing the system changes that would offer equal access to receive community services as institutional services[29]. The Real Choice grant of DAAS will address several of these issues. In addition to the revised application process described earlier, **the Real Choice Grant will provide information to applicants for nursing home placement or alternatives to institutionalization[30].** Under the grant, DHS will educate hospital discharge planners so that they understand the full array of community services available.

Along the same line, a self-advocacy group for persons with developmental disabilities, Arkansas People First, recently developed a grant application to provide information on alternatives to institutionalization to those considering admission to ICF/MR. Although the grant was not funded, ideas were formulated that may bear fruit in another setting.

An effective means to divert developmentally disabled individuals from institutions would be for community providers to better meet clients' short-term crisis needs. Crisis intervention in these situations would often make institutionalization unnecessary. More work also remains to serve school-aged children and those desiring services outside the clinic setting.

DMHS diverts applicants from possible institutionalization through the single point of entry application at the CMHCs.

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[27] GIST Recommendations #11, #100, #101, #102.
[28] GIST Recommendation #19.
[29] GIST Recommendation #12.
[30] GIST Recommendation #7.

Another recommendation to divert youth is to lower the age for DAAS' Alternatives waiver from age 21 to age 18 [31]. DAAS stated that this could be done and has begun the process of making that change.

CONSUMER DIRECTED CARE[32]

PRIORITY RECOMMENDATION: Increase consumer direction for waiver and State Plan services.[33]

The ninth ranked GIST recommendation is to increase consumer direction of services. DHS is poised for a tremendous increase in consumer direction of services. The DDS' PASS grant was developed and funded for that specific purpose. Its goals are to increase the number of self-advocates, improve the quality and number of direct support staff, and recreate the service delivery system for enhanced consumer direction through **mechanisms like community boards[34],** fiscal intermediaries, and other best practices in self-determination options. The grant will also assist in the development of new waiver services. In November, 2002, a consultant began analysis of the current DD system to develop and implement a pilot project to explore self-determination. The pilot will begin no later than 6/30/03.

The PASS Grant will develop community capacity by:

- increasing options for services through the use of fiscal intermediaries and governing boards
- tapping a new, untraditional workforce through hiring of family/friends who are not (and might never be) employees of traditional providers
- developing an infrastructure of community-wide natural supports, enhanced by activities of a service broker, and
- offering the level of supports each individual needs through person-centered planning.

Also, development of a pilot is underway to recruit and train self-advocates on how to speak up for themselves. This pilot will include approaches to make persons with disabilities, parents, providers, policy makers and members of the general public aware of the concept of self-advocacy, how one becomes a self-advocate, and the impact that self-advocates have on policy and programs. This pilot will facilitate networking among self-advocates and will empower self-advocates to present information to policy makers in a manner that they can understand and appreciate.

DDS' newly approved waiver amendment offers a self-directed services option, which allows individuals and guardians to employ their own staff and to choose the services they want.

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[31] GIST Recommendation #16.
[32] GIST Recommendation #97.
[33] GIST Recommendations #22, #105.
[34] GIST Recommendation #28.

Alternatives, another Medicaid Waiver program managed by DAAS, provides home and community based services to adults with disabilities. It offers two consumer-directed services:

- attendant care that allows the client to recruit, hire, supervise and approve payment of the attendant.
- modifications to the home environment that increase independence or accessibility.

DAAS' IndependentChoices is a demonstration waiver that will soon be entering its fifth year of consumer directed services. It substitutes traditional Medicaid personal care with a cash option. This cash option empowers the consumer to choose whom and at what time their personal care needs will be met. The IndependentChoices program was implemented in 1998 as part of a national research project conducted in four states. Arkansas was the first of the four states to implement the program, to reach the evaluation enrollment goals, and to begin receiving evaluation results. By all measurable standards, this innovative program is a success.

Arkansas is now expanding the same level of consumer direction to other Medicaid funded services. DAAS will use this successful demonstration program model to provide consumers with an option to exchange Medicaid nursing home benefits for a daily cash allowance. The proposed demonstration program is called NextChoice. The participants, individuals living in a nursing home and wanting to move into a non-institutional setting, may use the cash allowance to purchase the support services they require to live successfully in the community. It is well documented that most individuals prefer to remain in their own home, but many are forced to live in a nursing home due to limitations in the services and supports currently available in the community.

Arkansas will offer this voluntary program to recipients of Medicaid nursing home benefits through a vigorous social marketing campaign. Nurse Managers will determine participant eligibility and provide long-term counseling and management of a specific caseload. DAAS will monitor the dispersal of funds on a monthly and periodic basis; Arkansas Centers for Health Improvement ("ACHI") will manage the evaluative component of the grant; and a fiscal intermediary will disperse cash. All participating organizations are willing and able to field test various strategies and will cooperate with Health and Human Services in a process evaluation.

While Arkansas has made great strides in providing services to meet the growing needs of our state, many of the programs and services offered by the current Arkansas long-term care system are limited by the scope of the Medicaid State Plan, waiver restrictions, or other constraints imposed by the funding source. These programs traditionally require the participants to adapt their needs to the services defined by the funding agent. They have encouraged development of a provider network offering a restricted menu of services rather than one capable of customizing services to meet the specific needs of the participant .

DAAS is currently asking for proposals for Grants to assist Potential PACE Providers to evaluate the feasibility of becoming a PACE provider. These grants are being issued as part of the Real Choice initiative, the purpose of which is to help design and implement effective and enduring improvements in community long term support systems to enable people who are elderly and people who have a disability or long term illness to live and

participate in their communities. DAAS is in the process of building the necessary programmatic infrastructure to implement the PACE program as a Medicaid State Plan Option in Arkansas.

Building on the established strengths of our current home and community-based services foundation will offer participants additional options for consumer-directed care, enabling them to decide which services best meet their personal assistance needs, when services should be delivered, and by whom. This reform will further the State's mission to provide quality services in the least restrictive setting, enabling our participants to maximize their potential, while preserving and enhancing their human dignity.

The DDS PASS Grant, the Passages Grants, and Independent Choices are all examples of money following the person[35] While they are not yet instituted statewide, they are in the process of development with that objective in mind.

DDS is also meeting the GIST Recommendation to pilot the use of community boards to pool resources[36]. This initiative is included in the work of the PASS Grant. DDS believes that this concept holds promise as a means to manage the funds that will be necessary for the successful and appropriate delivery of individualized home and community-based services. The current lack of flexibility in funding stands as an obstacle to the common implementation of the recommendation, as well as the essential participation of consumers and family members to staff the boards. However, as the endeavor progresses, and with collaboration with the GIST, these barriers may be overcome.

To support these initiatives, DHS will respond to **another GIST recommendation by developing a database of long term care applicants and consumers**[37]**.** Although a database will require the assignment of staff at a time when personnel are stretched thin, DHS has the technology to accomplish this. DHS recognizes many benefits that can come from this database, e.g., measuring the costs of care per consumer, tracking the individual services provided, **measuring the cost of transition**[38], **calculating wait times for service**[39], determining work force needs. As DHS moves into an era where long term care services are no longer uniform but individualized to the specific needs of the consumer, the database will be an essential planning and policy tool.

Upcoming HIPAA confidentiality requirements pose a major barrier. Anticipating a possible solution, DMHS is applying for a grant to create a system to encrypt Social Security numbers. In July, 2002, DMHS submitted a mental health data infrastructure grant proposal for state uniform reporting to the Substance Abuse and Mental Health Services Administration (SAMHSA), and Center for Mental Health Services (CMHS). This proposal outlines DMHS' efforts to enhance the current data management and reporting system and envisions the modification and upgrade of the client demographic and services data sets collected from the CMHCs, as well as the implementation of a uniform consumer satisfaction survey to measure perceptions of access, quality and

[35] GIST Recommendation #97.
[36] GIST Recommendation #28.
[37] GIST Recommendation #38.
[38] GIST Recommendation #39.
[39] GIST Recommendation #13.

outcomes. If awarded, the grant award will be $100,000 and may be requested for three years.

Additionally, DHS is either currently meeting other administrative recommendations made by GIST or is willing to undertake them. These include **appointing a consumer representative to serve on the Medicaid Advisory Board[40], using State general revenue funds to leverage matching Medicaid federal funds whenever possible[41], and applying for grants to implement *Olmstead*-related programs and projects**[42]. As referenced in "The Catalyst Component", DHS divisions have been quite successful in obtaining grants from President Bush's New Freedom Initiative, grants that will fund pilots of *Olmstead* related projects. These successes are multiplying into ideas and initiatives, generating even more requests for grant funding. DDS received word on September 18, 2002, that it had been awarded a grant for $200,000 for review of and system change recommendations for its Family Support services.

All of these objectives outlined above demonstrate a major shift in the delivery of services for persons with disabilities. The State is conscious that it will take time, education, and much reassurance before this delivery system will be functional and beneficial to all the parties statewide. Nevertheless, the State stands ready to accomplish them.

QUALITY OF LIFE

Under *Olmstead*, institutional care will continue to have a role in the comprehensive system of care for those individuals with disabilities. Unfortunately, there are some individuals who, because of the severity of their disability, may have no alternative but an institutional setting. There are others for whom an institutional setting is either the most appropriate setting or it is their setting of choice. Many Arkansans consider the institution where they live to be their home.

Nevertheless there are always quality of life issues that arise in the institutional setting. The *Olmstead* decision and the principles born in its wake make the State aware that institutional settings should be integrated as much as possible into the life of the community to prevent the specter of segregation. Therefore, **DHS proposes to work in collaboration with the GIST to develop initiatives that promote community integration and involvement[43] as well as improve quality of life in institutions and congregate housing[44].** DDS will research current industry standards and various programs in other states in order to develop assessment tools and systems changes. DDS will include the input of providers, consumers, and institutional staff in developing these tools. DDS will provide technical assistance to nursing homes, the ICF/MR, and group homes to improve the quality of life. Quality of life requirements already exist in the federal requirements for nursing homes. DDS will revise its current licensing standards to include quality of life standards and will continue to encourage HDC accreditation. The GIST/DHS can take the information learned in the DDS project to raise the quality in other settings through training, workshops and licensing standards.

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[40] GIST Recommendation #44.
[41] GIST Recommendation #1.
[42] GIST Recommendation #33.
[43] GIST Recommendation #30.
[44] GIST Recommendation #32.

Developmental Day Treatment Clinical Services ("DDTCS") include preschool and adult services to the developmentally disabled community**. The GIST recommended more integration of this type of setting[45].** Within the DDTCS programs for pre-school aged children's programs, all but two or three programs in the state are integrated with typically-developing and developmentally delayed children learning in the same classroom. The integration of typically-developing and developmentally delayed children in pre-school DDTCSs is monitored as part of that program's reporting requirements to DDS, because the absence of such integration would result in segregation of individuals with disabilities at a very early age. Under Part C of I.D.E.A., the natural environments of home and regular day care services are a choice for infants and toddlers and their families. DDS continues to enhance community integration through its waiver that enhances the opportunity for adults to choose to live at home or their own apartment and obtain employment in their local community.

QUALITY ASSURANCE

Each of the four divisions of DHS that provide, contract for, or oversee long term services has an array of quality assurance activities. These include both internal quality improvement and external quality monitoring functions.

DAAS oversees the Nursing Home Ombudsman program statewide.

The Division of Medical Services, through the Office of Long Term Care (OLTC), regulates long term care facilities. These include 241 nursing homes for those with physical and age-related disabilities and 36 Intermediate Care Facilities for Mental Retardation (ICF/MR) for people with developmental disabilities.

The Division of Mental Health Services has administrative responsibility for its facilities and the Arkansas State Hospital (ASH) is regulated by the Arkansas Department of Health. The Arkansas Health Center is inspected by the Office of Long Term Care. ASH is accredited by the Joint Commission on the Accreditation of Health Care Organizations (JCAHCO). The fifteen Community Mental Health Centers and three clinics must be accredited by either Council of Accreditation of Rehabilitation Facilities ("CARF") or JCAHCO to maintain certification by the Division. The Division monitors compliance with deficiencies.

The Division of Developmental Disabilities Services regulates 97 licensed providers and over 200 certified providers of community services, who deliver both center- and home-based services. The six state-operated ICF/MR, or Human Development Centers, are governed by the Developmental Disabilities Services Board and are regulated by OLTC. Accreditation of DD community providers has been encouraged. At least three providers have become accredited.

A subcommittee of the DDS Board is working towards a quality assurance process that will help standardize current practices across all six Human Development Centers. Based upon the completion of the process it is proposed that a continuous quality improvement design be established that will result in positive outcomes for the quality of service within these facilities. A quality improvement/quality assurance unit was

[45] GIST Recommendation #29.

established September 1, 2002, that will coordinate quality assurance activities across the service delivery system under the auspices of DDS.

The GIST's sole recommendation in the area of quality assurance was that the Governor form **an ongoing commission to address Continuous Quality Improvement (CQI) for disability issues[46].** This recommendation will be referred back to the GIST to clarify the goals, barriers, action steps, funding, and timeframes regarding this matter. DHS will work with the GIST to review performance indicators, processes and models.

SUPPORTED HOUSING

PRIORITY RECOMMENDATION: Use existing housing funds to finance integrated housing and community facilities[47]

In addition to processes described in the "Access to Services" section and the provision of Medicaid and waiver services, all set out above, there are supportive services instrumental to a comprehensive plan for successful integration of disabled persons into the community. These issues are predominantly staffing/work force issues of direct care services, housing for persons with disabilities, competitive employment, and transportation.

One priority GIST Recommendation dealt with affordable and accessible housing for persons with disabilities. With over 25,000 persons living in institutions in Arkansas, the potential of demand for community-based services and housing is considerable.[48] The ADA's mandate for community integration assumes the availability of affordable and accessible housing[49]. The Olmstead Working Group recommended the appointment of a supported housing task force. At the direction of Governor Mike Huckabee, Arkansas Rehabilitation Services (ARS) convened the Governor's Supported Housing Task Force to examine the need for affordable and accessible housing for persons with disabilities[50]. On June 6, 2002, they submitted the **Governor's Task Force on Supported Housing Plan**[51] to the Governor.

With funding provided by ARS, the Task Force consulted with the Technical Assistance Collaborative (TAC), a non-profit organization from Boston that provides assistance to local and state governments with strategies to develop housing[52]. After meeting with consumers, advocates, and managers of housing and services in Arkansas, TAC consulted with the Task Force to further refine the strategies the Task Force had produced[53]. They addressed the following issues:

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[46] GIST Recommendation #115.
[47] GIST Recommendation #115.
[48] Governor's Supportive Housing Task Force, *Governor's Task Force on Supportive Housing Plan,* June 6, 2002, p.4.
[49] Id.
[50] Id.
[51] Incorporated by reference; see Index. Also, GIST Recommendation #5.
[52] Id., p.5.
[53] Id., p.6.

1. Income is the superceding issue, not disability. Most people with disabilities receive SSI, which is approximately $545.00 per month. Therefore, they are forced to spend an average of 68% of the income for housing costs.
2. People with various disabilities prefer various housing arrangements.
3. Elderly as well as younger persons with disabilities want more "normal housing", i.e., an individual apartment or home. These individuals prefer more community integration as opposed to residential facilities known for housing a particular disability group.

A strategy to make affordable housing more available will require additional funds for a full range of housing resources, i.e., home modifications, rental subsidies, and development of multi-family units[54]

The Supported Housing Task Force recommended the following:

A. Utilization of existing housing
B. Production of affordable housing stock for *Olmstead* affected persons
C. Policy direction on affordable housing.[55]

As an initial implementation effort, the Supported Housing Task Force proposed the creation of a pilot program in cooperation with the GIST, to operate in an urban community and a rural community. They recommended that DHS staff direct the pilot effort, utilizing consultants as needed. Specific tasks would include:

- Recruitment and identification of individuals living in institutions but capable of living in the community;
- Assessing their service and housing needs;
- Linking those persons with service providers;
- Assisting the pilot group with obtaining bridge rental subsidies through the HOME Program and then permanent subsidies through the local Public Housing Authorities, and
- Monitoring and evaluation of the process.

Finally, the Task Force continues to meet in order to review developing efforts and refine their committee recommendations for implementation. They are moving forward with a Request for Proposal from ADFA to Housing Authorities for housing vouchers for people transitioning from institutional settings. The Task Force is also working on maximizing federal dollars through the McKinney Act coming in Arkansas through counties and locales coming together to form "Continuum of Care Groups". The Task Force has increased its utilization of these funds to $2 million, and plans to reach the maximum of $4 million.

[54] Id.
[55] Id., pp. 6-8.

STAFFING

In a comprehensive system of care for persons with disabilities, whether in an institutional setting or a community/home-based setting, direct care and support services are a critical component. Professional direct care workers are an indispensable necessity. Unfortunately, Arkansas has a severe shortage of direct care workers available to meet the increased demand expected as a secondary result of the emphasis on community settings for persons with disabilities. The GIST/ Staffing Subcommittee submitted detailed recommendations to address this need. Their recommendations demonstrated great understanding and knowledge of work force/ staffing issues. **The GIST/ Writing Committee distilled these recommendations into two categories: recruitment[56] and retention[57].** While the availability of workers is largely a function of the economy and market forces, there are substantive steps the State can undertake. Specifically, worker shortages can be addressed in a cooperative effort between four primary entities: the GIST Commission, DHS, the Work Force Investment Board, and private providers. Much discussion has already occurred between the GIST/Staffing Subcommittee and the Workforce Investment Board ("WIB"). These entities will continue to address the in-depth recommendations on recruitment and retention.

DHS is currently undertaking several efforts to meet some of these critical needs. **DDS has communicated to Partners with Inclusive Communities, its UAMS subcontractor, their desire for the PASS Grant recruitment campaign to collaborate with the WIB**[58]. Through the PASS grant, with supplemental funding through the Real Choice grant, DDS is funding a recruitment campaign through Partners with Inclusive Communities. **The DAAS funding will include an effort to help change attitudes about care-giving**[59]. **The GIST recommended coordination of training and employment[60].** The PASS grant is also funding a training program for direct support professionals for persons with developmental disabilities, again subcontracted to Partners. The WIB is working with an Hispanic organization to recruit personnel for this job training.

Even though professional caregivers are indispensable, they cannot supplant the role filled by family members, relatives, neighbors, friends, and other natural supports The development of broader natural supports, including faith-based organizations, is a resource not only to **strengthen family care-giving[61],** but also enable the disabled person's integration into community life and activities. **Volunteer caregivers are an additional resource that the GIST recommended[62].**

To support care-giving by family members, which many times is the predominant resource**, the GIST recommended that restrictions be eased on hiring family caregivers[63], and that respite care for family caregivers be expanded**[64]. The

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[56] GIST Recommendations #83, #84, #85, #86, #88.
[57] GIST Recommendations #62, #63, #72, #74, #75, #77, #79, #80, #81, #82.
[58] GIST Recommendations #64, #65, #66.
[59] GIST Recommendation #59.
[60] GIST Recommendations #67, #68, #69, #70, #71.
[61] GIST Recommendation #109.
[62] GIST Recommendation #34.
[63] GIST Recommendations #51, #87.

overwhelming majority of long term care in this country is provided by family members. Medicaid policy currently allows use of family caregivers, with the exception that the caregiver cannot be a parent of a minor child or a guardian of an adult. DDS recently received approval from Centers for Medicare/Medicaid Services ("CMS") for an amendment to the Medicaid Waiver that allows payment to parents of adult children.

Regarding respite care, DAAS currently provides respite care through Elder Choices. The Area Agencies on Aging provide some respite care through Older Americans Act. Adult Day Help Centers can get extended stay hours and some overnight. DDS provides respite through Special Needs funds and through HDCs. Funding is included in community-based program contracts to provide individual family supports which can be used to pay for respite. Additionally, CMS has received approval for a respite waiver scheduled to begin November, 2002. DDS plans to explore and identify ways these options can be improved and expanded. DDS is also pursuing outside grant opportunities.

An additional related GIST recommendations**, to create a statewide registry of direct care workers**[65] will be included in ongoing discussions with the GIST, WIB and Arkansas Department of Health. There is seed money to begin a statewide registry in the Real Choice Grant. DAAS is talking with the WIB to assist. Additionally, through the PASS Grant, curriculum development for direct support staff has been completed. Train-the-trainer workshops are being scheduled around the state.

TRANSPORTATION

It is hard to receive community services if you cannot get to them. GIST transportation recommendations ranged from the need for an overall state plan to the issues of non-emergency transportation, attendant services, and reimbursement [66]. There are currently transportation services provided by various DHS divisions as well as various state agencies. There is no overall public transportation system that can provide dependable, organized transportation. This recommendation needs to continue to be addressed by the GIST and the appropriate state agencies.

EMPLOYMENT

The Arkansas Rehabilitation Services offers vocational rehabilitation services to Arkansans with mental, physical and sensory disabilities to enable them to obtain and keep meaningful jobs. Services include counseling and evaluation to ensure a client's strengths are identified and maximized, physical restoration and medical services to prepare clients physically, academic and vocational training to obtain high quality jobs commensurate with their aspirations and abilities, and the equipment to ensure clients are adequately prepared to enter the workplace.

In addition to these programs, HIRE, Inc. is a non-profit supported employment agency that has received a Work Force Coordinating Grant from the Office of Disability Employment Policy of the Department of Labor. This project is designed to expand and better coordinate Arkansas statewide *Olmstead* planning and implementation efforts

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[64] GIST Recommendation 89.
[65] GIST Recommendation #61.
[66] GIST Recommendations #110, #111, #112, #113.

through the coordination and delivery of competitive customized employment opportunities that will enable individuals with disabilities to live and work in their own communities.

THE CHANGE COMPONENT

The Collaboration Component lays out the most current information about all of the actual work coming together from all directions: the State, the GIST, the public, the courts, the federal government. It is clear that much energy has gathered surrounding the work of redefining and redesigning the array of services available to persons with disabilities in order to afford them equal opportunity. While much has already happened, many challenges lie ahead. Those continuing challenges are addressed in this section.

The reason the challenges are enormous is because the barriers are enormous.

- Funding is becoming an increasing concern. In many ways, it represents the most serious challenge to the transformation of services for persons with disabilities. In addition to the state's tight budget constraints, the rigidity of the use of many of the funds, both federal and state, creates a barrier to the immediate, dynamic changes and opportunities ahead. Even the services currently in place grow evermore expensive to maintain at the present level.
- Because of the myriad of agencies, departments, providers, regulations, federal and state laws, the organization of the long-term care system is far from optimal.
- Institutional bias permeates long-term care, whether it is regarding eligibility, services, or funding.
- Arkansas is a rural state, creating innumerable barriers to delivery of services. With no statewide public transportation, accessibility to the services that are available is impossible for some people in remote areas. It also makes disseminating information regarding the menu of services more difficult. Public housing is not available in remote areas. Workforce issues are exacerbated as well.
- Most people are uninformed about *Olmstead* and its underlying principles. The prejudice toward people with disabilities, the fear of disabilities, the paternalistic attitude common amongst the general population are all barriers to disabled persons achieving equal opportunity in the community. It will take time and effort to help people understand and grow accustomed to the new way of viewing the lives and hopes of individuals with disabilities --- to move from a charity-based perspective to a rights-based perspective. The *Olmstead* decision represents to disabilities integration what *Brown vs. Board of Education* represented to racial integration.

Arkansas is a state that is very dependent on Medicaid and federal funds. Because of our heavy use of federal matching funds to make many of our current programs possible, the flexibility to transfer funds from one program to another is limited. Therefore, the State will have to be even more creative in developing solutions to these issues. It has already begun through grants, which the State trusts will demonstrate the benefits of improved lives, saving funds, better coordination, more responsive systems. From there, the State will be able to utilize that evidence and data to spread across the state. One such example is Together We Can. TWC serves the family as a whole and keeps families together by integrating and coordinating client-specific services for children with multiple needs. Participating Arkansas agencies include the Department of Health, Department of Education, and five divisions of the DHS. It began in only a few counties, and has grown to cover 26 counties; ten more are expected to join by July 1, 2003. It uses three different funding streams so that when rules preclude use of one

funding source, another can be utilized. Both federal and state funds are used for this program.

The following tables of action steps attempt to lay out timeframes, funding, and responsibility. While Arkansas has aggressively sought and received competitive grants, grants are effecting productive changes. Grant funding allows DHS to develop pilot projects, which offers persons with disabilities and their families the chance to experience the effects of a possible program, it allows providers time to adapt their services so that their economic viability is not jeopardized, and affords DHS the opportunity to gather the necessary evidence to support instituting the program on a broader scale. Grants also provide a means to facilitate the use of current funds in new and more responsive ways.

Where programs are being introduced through grants, a completion date for the grant will be given in the Table. At that time, the program will have to be evaluated and reviewed by the pertinent agencies, divisions and other groups, including the GIST, to determine if broader application and availability are warranted and possible. The Arkansas *Olmstead* Plan would then need to be modified if appropriate. DHS recommends that any modifications follow the same process as has the development of this plan:

- A review and evaluation by the GIST;
- Recommendations made by the GIST;
- A review and evaluation by the appropriate state agencies;
- Revision of the plan with action steps written by DHS incorporating the GIST recommendations with the State's resources.

The future holds multiple uncertainties. However, two certainties remain: the need for services is certain, and the State's obligation to meet those needs is certain. The State will have to approach these changes as they become apparent and as the resources for their accomplishment become available. The success of *Olmstead* principles in Arkansas, though, will require much more than the efforts and resources of the State. Ultimate success will require the efforts of all interested parties: persons with disabilities, their families, their guardians, their teachers, their doctors, their caregivers, their advocates, their communities. Working together creates the greatest potential for success. If Arkansans will marshal their resources, then the synergy that has been developing can continue to build. The commitment to that common effort is what will determine the ultimate success of *Olmstead* in Arkansas.

ACTION STEPS:

ELEMENT	ENTITY	ACTION	FUNDING	COMPLETION
1. GIST Body	Governor's office	Appoint members	$3000	ONGOING
2. Revise and/or clarify the Nurse Practice Act	GIST, DHS, State Board of Nursing, and AR. Dept. of Health	Draft revisions	N/A	Spring, 2003
3. Mental Health Insurance Parity	Mental Health Coalition	Draft legislation	N/A	Spring, 2003
4. Reduce DDS Waiver Waiting List	DDS GIST Legislature	Funding requested	$6.4 million in general revenue for the biennium	July 1, 2003 through June 30, 2005
5. Reduce response times for waiver service ("fast track")	DAAS	Replicate other models, i.e., Colorado, New Hampshire	$100,000 – $300,000	July 1, 2003 Through June 30, 2005
INFORMATION FOR ALTERNATIVES TO INSTITUTIONALIZATION	**SEE ACTION STEPS 6, 7 & 8**			
6. Face-to-face assessment for all applicants	DHS	Study pilot assessment; Study other models – Maine, Mich.; Develop action plan	To be determined	July 1, 2003 through June 30, 2005
7. Pilot assessment	DAAS	In process	Funded	July 1, 2003
8. Informational component with Consumer Website, Service Directory & Toll-free phone number	DHS	Develop enhanced website with electronic service directory; Institute toll free number; Hire and train staff	To be determined	June 30, 2004

RESTRUCTURE MENTAL HEALTH SERVICE DELIVERY	**SEE ACTION STEPS 9-13**			
9. Funding for mental health adult acute care	DMHS	Request funding	$5.8 million annually	July 1, 2003 through June 30, 2004
10. Shift funds to children's outpatient services	DMHS	Analyze spending patterns; Work on outpatient service options; Change Medicaid State Plan	To be determined	June 30, 2004
11. Improve forensic services	DMHS	Evaluate within 30 days; Admit 310s based on triage	$800,000	Begin July, 2003; then ongoing
12. Revise commitment laws	DMHS & MH Coalition	Draft revisions	N/A	Spring, 2003
13. Revise CMHCs standards and accountability	DMHS	Review and revise contracts	N/A	July, 2003
14. Facilitate transitions ---Support services ---Assessments	DAAS	Passages Grant; Transitions Grant; Next Choice Grant	Funded	Ongoing
15. Amend 1915c waivers to include transition costs	DAAS DDS	Amend waivers; Submit to CMS	Cost neutral	January 1, 2004
16. Lower age for Alternatives Waiver from 18 to 21	DAAS	Amend waivers; Submit to CMS	Cost Neutral	January 1, 2004
CONSUMER DIRECTION	**SEE ACTION STEPS 17-21**			
17. PASS Grant initiatives; self-advocacy; direct care staff; service delivery; and, pilot use of community boards	DDS	Identify pilot counties; Determine method to operationalize	$1,000,000	October 1, 2004

18. Expansion of Independent Choices	DAAS	Currently in progress	N/A	January, 2003
19. Alternatives ---self-directed care ---home modifications	DAAS		N/A	January, 2003
20. Consumer-directed nursing home care	DAAS	Implement Long Term Care Innovations Grant	$410,557	January 1, 2004
21. Database for long term care consumers	DHS	Establish workgroup	Undetermined	July 1, 2005
22. Enhance data collection of DMHS and CHMCs	DMHS	Hire staff; Work with CMHCs to upgrade data systems; Establish workgroup	$50,000 annually	Stage 1: October, 2003 Stage 2: October, 2005
23. Uniform consumer satisfaction survey	DMHS	Gather current instruments; Develop single instrument; Implement pilot	$50,000 annually	Stage 1: October, 2003 Stage 2: October 2005
24. Consumer representative on Medicaid Advisory Bd.	DMS	Completed	N/A	Completed
25. Apply for grants to improve the home and community based care system	DHS	Ongoing	N/A	Ongoing
26. Quality Assurance Commission	GIST; DHS	GIST input from consumers & providers; Include q/a requirements in DHS contracts; monitor plan	N/A	January, 2003
29. Revise Regulations for hiring family caregivers	DAAS DDS			Completed
30. Registry of direct care workers	DAAS	Issue RFP to establish Worker Registry	$80,000	January 1, 2004

Appendix A

MEDICAID FACTSHEET
LONG TERM CARE

LTC Expenditures
as % of Total Medicaid Program:
SFY98: 28.59%
SFY99: 26.83%
SFY00: 26.15%
SFY01: 23.89%
SFY02: 35.23%

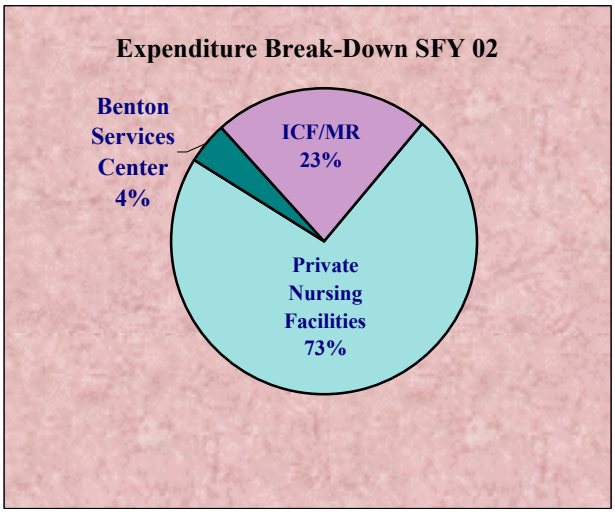
TWO LEVELS OF FACILITY CARE:
1. Nursing Facility Services
2. Intermediate Care Facility Services for the Mentally Retarded and Developmentally Disabled (ICF/MR)

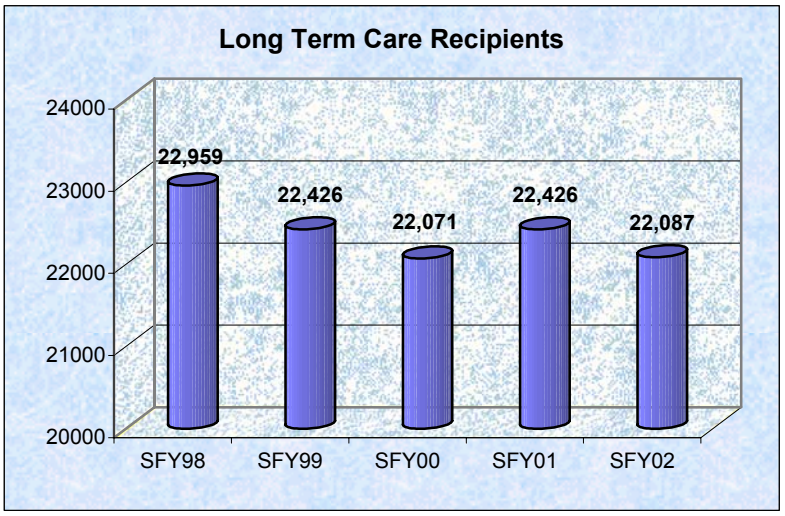
Total Skilled Nursing Facility Beds: 24,923
Total ICF/MR Beds: 1,797

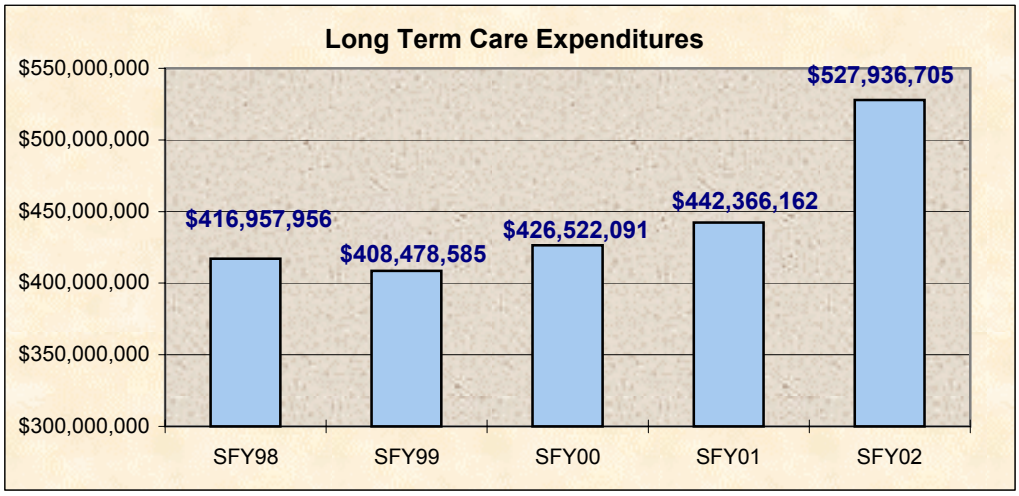
There are over 20,061 active Certified Nursing Assistants in Arkansas. The Office of Long Term Care (OLTC) handles the license renewals, approves training sites and programs and maintains records.

Nursing Facilities: Benton Services Center (public); 230 *private* nursing homes.

ICF/MR: *6 public* human development centers in Alexander, Arkadelphia, Booneville, Conway, Jonesboro, and Warren.
4 *private* pediatric ICF/MR facilities : Arkansas Pediatric, Brownwood, Millcreek and Easter Seals.
30 *private* non-profit ten-bed ICF/MR for adults.







Source: LTC; Dss Reports; HCFA 2082; Medicaid Statistical Reports

MEDICAID FACTSHEET
DDS ACS WAIVER

DDS ACS Waiver Expenditures
as % of Total Hosp/Med Exp:
SFY98: 2.07%
SFY99: 3.13%
SFY00: 3.79%
SFY01: 4.56%
SFY02: 4.32%

Medicaid offers certain home and community based services as an alternative to institutionalization. These services are available for a limited number of eligible individuals with a developmental disability who would otherwise require an ICF/MR level of care. The home and community based services to be provided through this waiver are referred to as the DDS ACS (Alternative Community Services) Waiver.

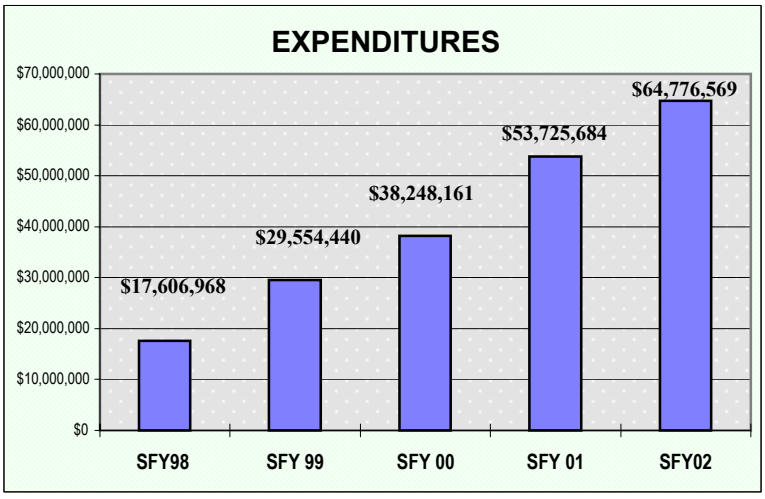
The DDS ACS Waiver is administered by the Division of Developmental Disabilities

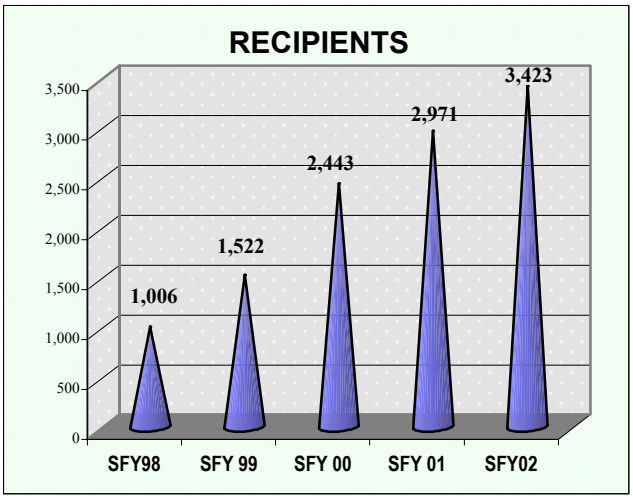
Services provided under this program are as follows:

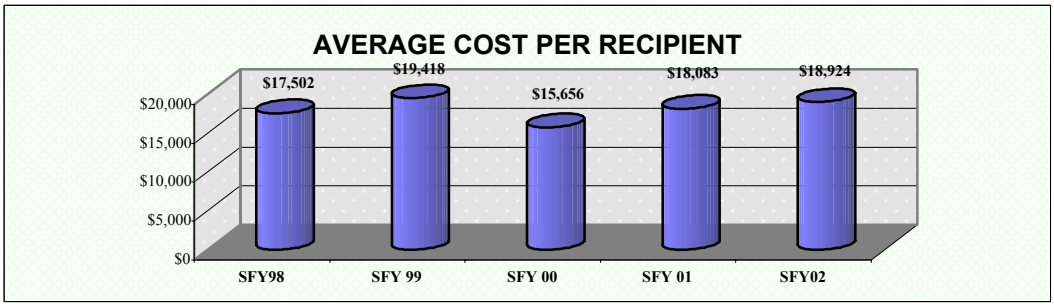
- **Crisis Abatement Respite Care Services**
- **Integrated Supports Services**
- **Supported Employment Services**
- **Physical Adaptation Services**
- **Specialized Medical Supplies**
- **Case Management Services**
- **Consultation Services**
- **Crisis Center/Intervention Services**

Home and community based waiver services are available only to individuals who are not inpatients (residents) of a hospital, nursing facility (NF), or intermediate care facility for the mentally retarded (ICF/MR).

ACS Waiver Program services do not require Prior Authorization.







Source: DSS Reports; Medicaid Statistical Reports; Medicaid Provider Manual

MEDICAID FACTSHEET
ELDERCHOICES

ElderChoices Expenditures
as % of Total Hosp/Med Exp:
SFY98: 2.66%
SFY99: 2.80%
SFY00: 3.00%
SFY01: 2.74%
SFY02: 2.20%

ElderChoices is a home and community based waiver program available to a limited number of individuals ages 65 and older who require an intermediate level of nursing facility care. Services are provided in the patient's home to preclude or delay institutionalization.

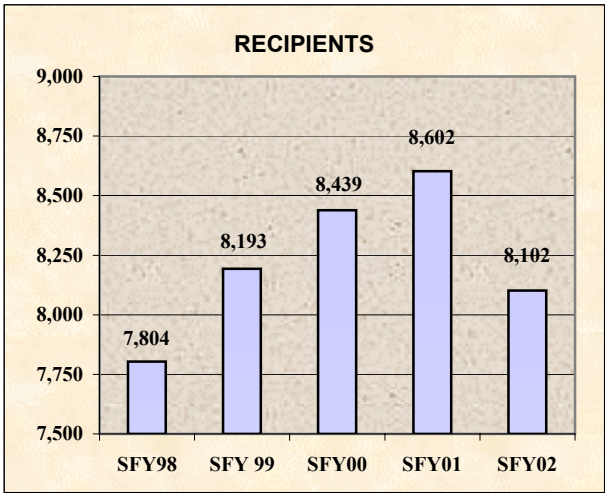
Provided Services: Adult Foster Care,Chore Services, Home Delivered Meals, Homemaker Services, Personal Emergency Response System, Adult Day Care, Adult Day Health Care, and Respite Care.

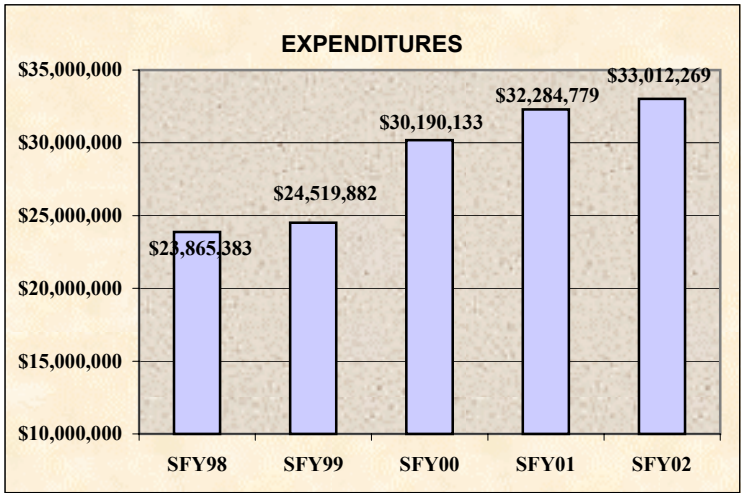
ElderChoices services are tailored to the social and medical needs of the recipient through a comprehensive assessment by a registered nurse.

ElderChoices became effective July 1991.

AVERAGE COST PER RECIPIENT

	SFY97	SFY98	SFY99	SFY00	SFY01	SFY02
Number of Recipients	7,681	7,804	8,193	8,439	8,602	8,102
Census of Active EC Cases as of June 30 Each Year			6,194	6,473	6,308	5,867
State General Revenue	$5,573,552	$6,455,586	$6,637,532	$8,187,564	$8,710,433	$8,999,145
Federal Revenue	$16,667,279	$17,409,797	$17,882,350	$22,002,568	$23,574,345	$24,013,125
Total Expenditures	$22,240,831	$23,865,383	$24,519,882	$30,190,133	$32,284,779	$33,012,269
Exp./Recipient	$2,896	$3,058	$2,993	$3,577	$3,753	$4,075





Source: DSS Reports; Medicaid Statistical Reports; Medicaid Provider Manual

MEDICAID FACTSHEET
Alternatives Waiver

Alternatives Waiver Expenditures
as % of Total Hosp/Med Exp:
SFY98: 0.11%
SFY99: 0.37%
SFY00: 0.59%
SFY01: 0.70%
SFY02: 0.76%

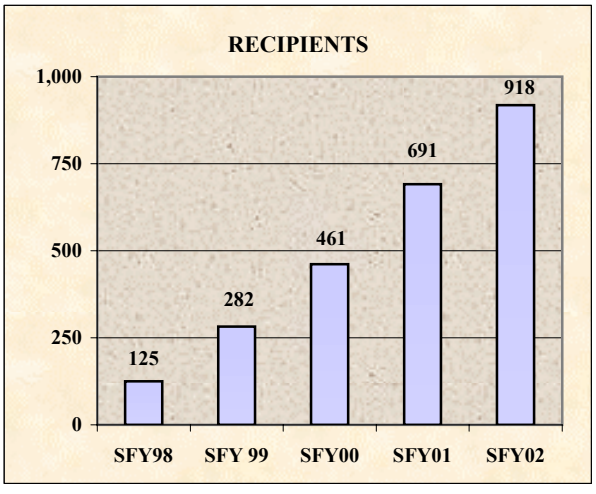
Alternatives Waiver services are designed to maintain Medicaid eligible persons at home in order to preclude or postpone institutionalization of the individual. These services are available to disabled individuals age 21 through 64, who have received a determination of physical disability, and who, without the provision of home and community-based services, would require a nursing facility (NF) level of care. Their income must be equal to or less than 300% of the SSI eligibility limit.

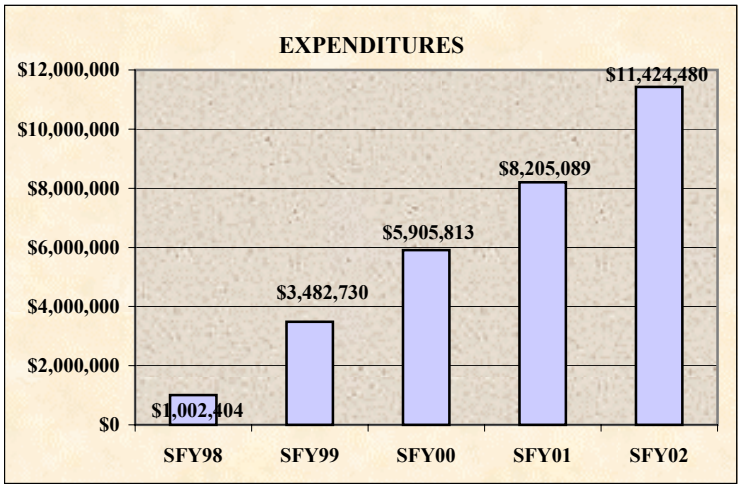
Provided Services:

Attendant Care, Environmental Accessibility, and Adaptations/Adaptive Equipment

AVERAGE COST PER RECIPIENT

	SFY98	SFY99	SFY00	SFY01	SFY02
Number of Recipients	125	282	461	691	918
Total Expenditures	$1,002,404	$3,482,730	$5,905,813	$8,205,089	$11,424,480
Exp./Recipient	$8,019	$12,350	$12,811	$11,874	$12,445





Source: DSS Reports; Medicaid Statistical Reports; Medicaid Provider Manual

MEDICAID FACTSHEET
PERSONAL CARE SERVICES

Personal Care Expenditures as % of Total Hosp/Med Exp:
SFY98: 7.08%
SFY99: 6.44%
SFY00: 5.74%
SFY01: 4.79%
SFY02: 3.57%

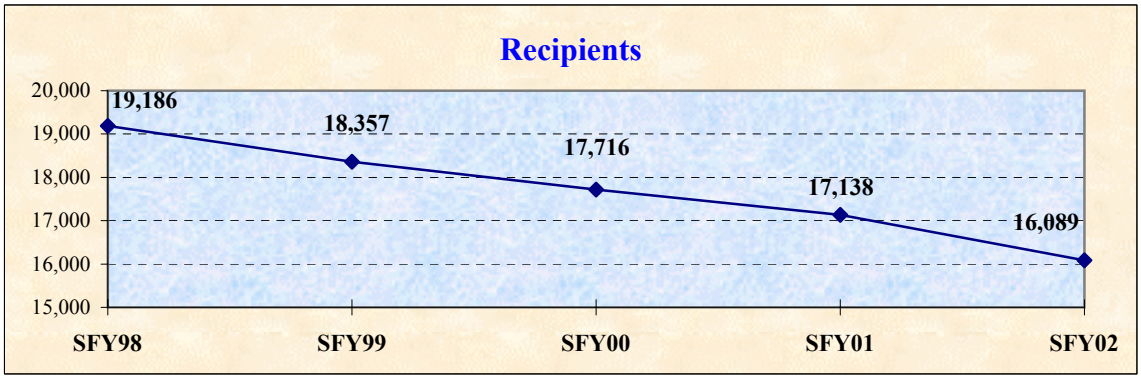
Personal Care Services include medically necessary assistance with defined activities of daily living, such as grooming, bathing, food preparation and eating, etc. Services are rendered in the home.

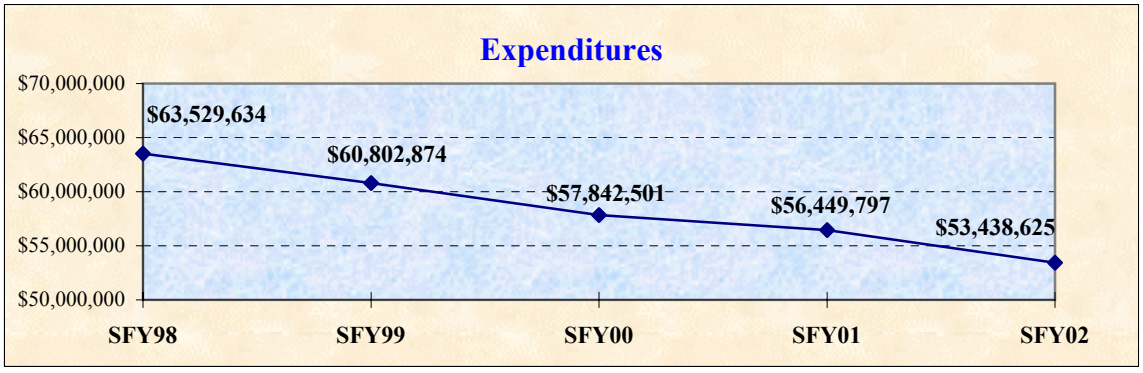
For EPSDT recipients, under age 21, services may also be provided in DDS community provider facilities or in the public schools. (DDS = Division of Developmental Disabilities Services). Effective for dates of service on and after December 1, 1997, the Arkansas Medicaid Personal Care Program requires prior authorization (PA) of services for clients under the age of 21.

Personal Care Services is an optional program.

Medicaid imposes a 64-hour benefit limit, per month, per client, on personal care aide services for clients aged 21 and over. The 64-hour limitation applies to dates of service on and after August 1, 1997.

The Arkansas Department of Human Services (DHS) is conducting a scientific study of a consumer-directed personal care program. The program, called "IndependentChoices," operates under the authority of an 1115 research and demonstration waiver approved by the Health Care Financing Administration (HCFA). IndependentChoices offers an opportunity to Medicaid-eligible adults with disabilities (age 18 and older) and the elderly who qualify for personal care, to self-direct their care. IndependentChoices provides qualifying clients with counseling and training to assist them in administering their personal care. Participants also receive a cash allowance with which they may hire an assistant or purchase other services and items related to their personal care. The goal of the IndependentChoices Program is to evaluate the efficiency and feasibility of a Medicaid personal care program that offers consumer direction with a monthly cash allowance.



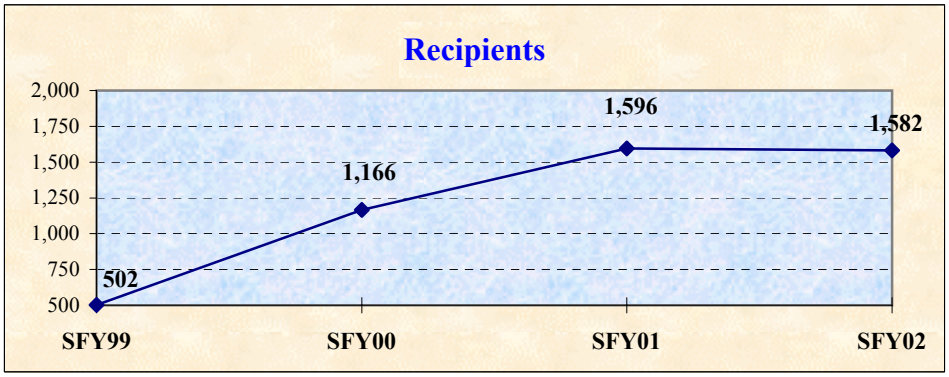


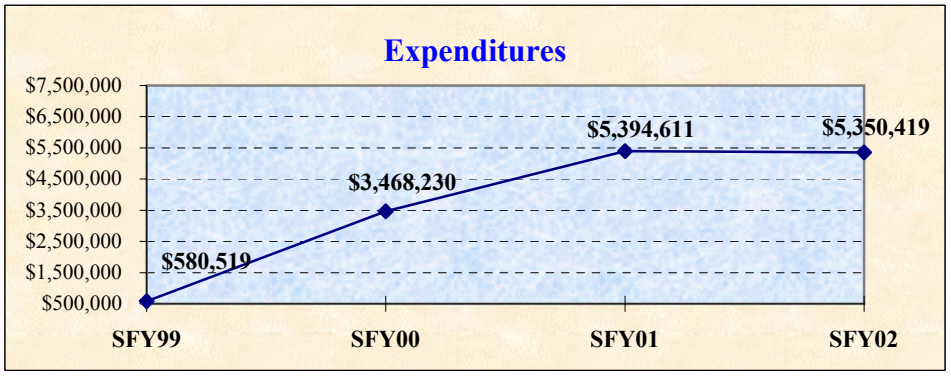
Source: DSS Reports; Medicaid Statistical Reports; Medicaid Provider Manual

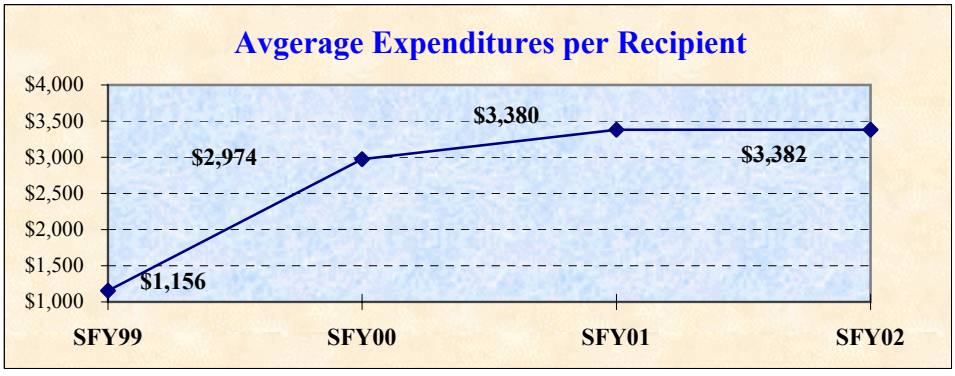
MEDICAID FACTSHEET
INDEPENDENT CHOICES

Independent Choices
Expenditures as %
of Total Hosp/Med Exp:
SFY99: 0.06%
SFY00: 0.34%
SFY01: 0.46%
SFY02: 0.36%

IndependentChoices offers an opportunity to Medicaid-eligible adults with disabilities (age 18 and older) and the elderly who qualify for personal care, to self-direct their care. IndependentChoices provides qualifying clients with counseling and training to assist them in administering their personal care. Participants also receive a cash allowance with which they may hire an assistant or purchase other services and items related to their personal care. The goal of the IndependentChoices Program is to evaluate the efficiency and feasibility of a Medicaid personal care program that offers consumer direction with a monthly cash allowance. IndependentChoices is administered by the Division of Aging and Adult Services (DAAS).







Source: DSS Reports; Medicaid Statistical Reports; Medicaid Provider Manual

MEDICAID FACTSHEET
HOME HEALTH SERVICES

Home Health Expenditures
as % of Total Hosp/Med Exp:
SFY98: 1.46%
SFY99: 1.48%
SFY00: 1.22%
SFY01: 0.98%
SFY02: 0.71%

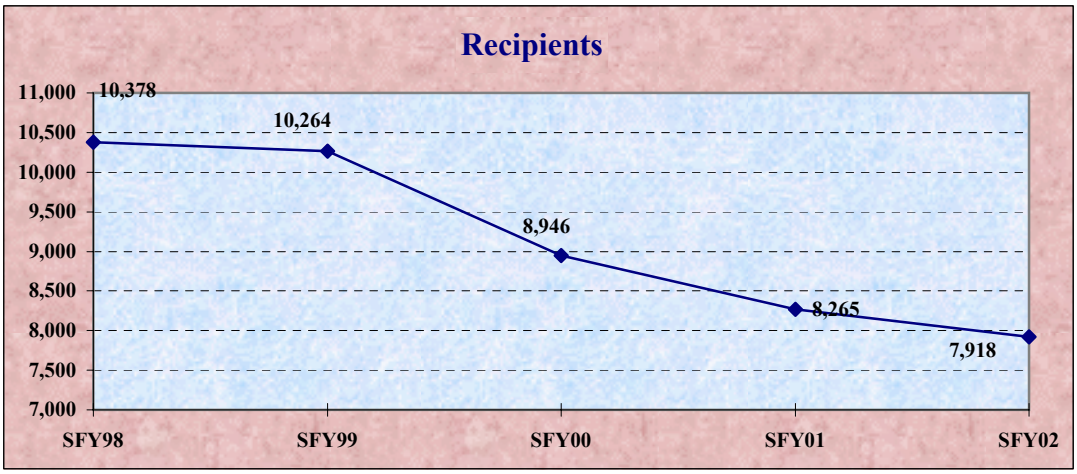
Home Health Services provides skilled nursing, home health aide and physical therapy services in the home.
Services are for part-time, intermittent care, for a few hours a day, one or more times a week.
Services are provided in the patient's residence.

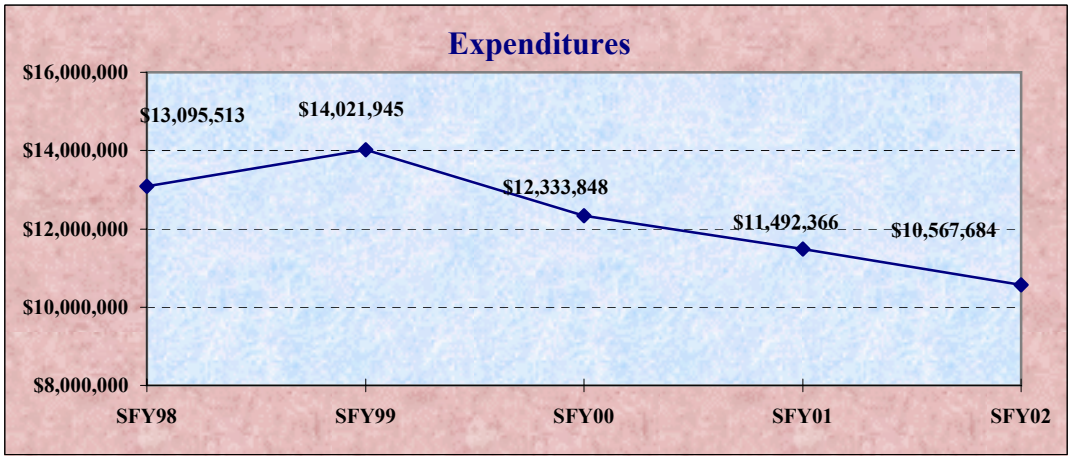
All home health services are based on the patient's attending physician's written prescription. Home health services provide periodic nursing care, under the direction of a physician, to preserve life and prevent or delay the necessity of inpatient care for Medicaid eligible persons.

Administered by the AR Department of Health and private providers.
Home Health Services is a federally mandated program.

Benefit limit: 50 visits per State Fiscal Year (extensions may be granted)

The main intent of Home Health Services is to enable individuals to remain in their homes, thereby reducing the need for costly institutional care.
PCP Referral Required.





Source: DSS Reports; Medicaid Statistical Reports; Medicaid Provider Manual

MEDICAID FACTSHEET
PRIVATE DUTY NURSING

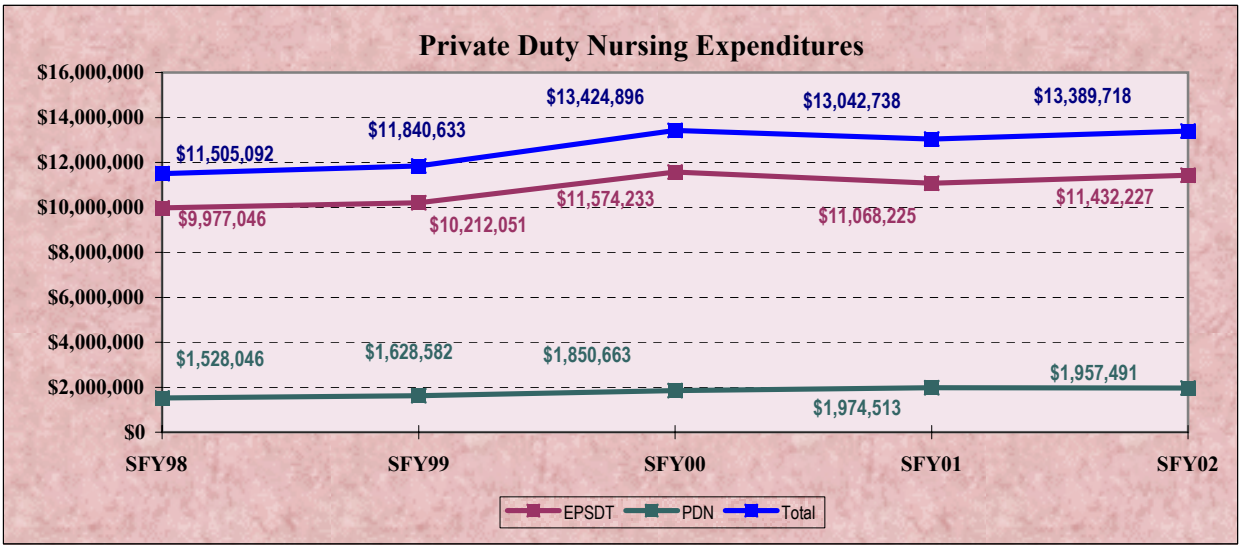
Private Duty Nursing Expenditures
as % of Total Hosp/Med Exp:
SFY98: 1.28%
SFY99: 1.26%
SFY00: 1.33%
SFY01: 1.11%
SFY02: 0.89%

Private Duty Nursing (PDN) Services are provided by a registered nurse and/or licensed practical nurse under the direction of the recipient's physician. Services are rendered in the recipient's place of residence.

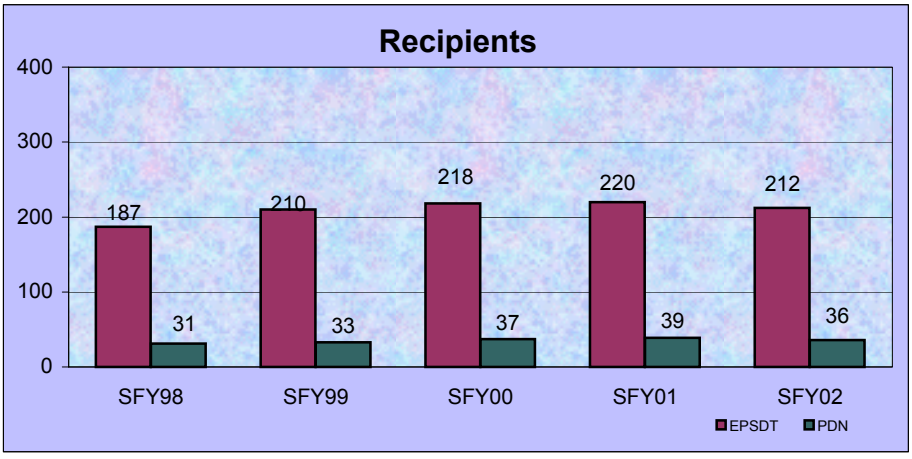
Private Duty Nursing Services are *not* covered in a hospital, boarding home, intermediate care facility, skilled nursing facility or a residential care facility. $80 per month, per recipient benefit limit on Private Duty Nursing medical supplies; limit may be extended.

ELIGIBILITY

PDN services may be covered for Medicaid eligible ventilator-dependent recipients when determined medically necessary and prescribed by a physician. Coverage may also be available for high technology non-ventilator dependent recipients in the Child Health Services Program (EPSDT) who require: Prolonged Intravenous Drugs; Parenteral Nutrition; Oxygen Supplementation; Tube Feeding; and Peritoneal Dialysis.



EPSDT = Private Duty Nursing/EPSDT; PDN = Private Duty Nursing, non-EPSDT



Average Expenditure Per Recipient, SFY02	
EPSDT	$53,926
PDN	$54,375
Total	$53,991

Source: DSS Reports; Medicaid Statistical Reports; Medicaid Provider Manual

MEDICAID FACTSHEET
DDTCS

DDTCS Expenditures
as % of Total Hosp/Med Exp:
SFY98: 4.73%
SFY99: 4.80%
SFY00: 5.19%
SFY01: 4.76%
SFY02: 4.14%

Services must be rendered at a Comprehensive Day Treatment Center:

* diagnosis and evaluation
* habilitative training
* provision of noon meal

Services in qualified facilities may be covered only when:

* they are provided to outpatients
* they are determined medically necessary
* provided according to written prescription
* provided according to written plan of care

Administered by the Division of Development Disabilities

Levels of Care:

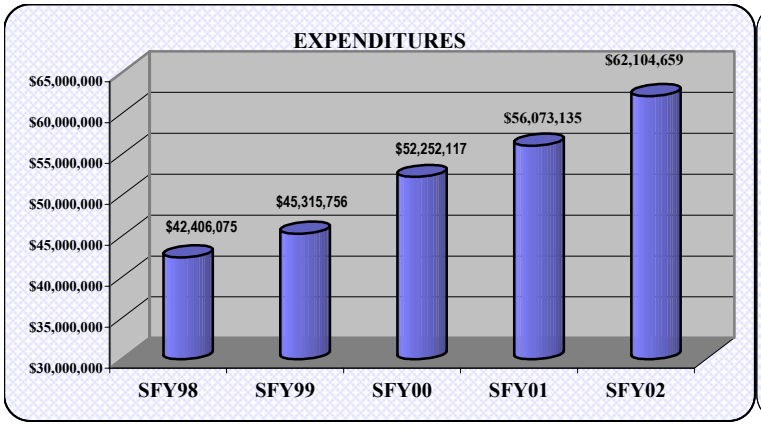
1. Early Intervention: facility based provision of one-to-one staff/client training in conjunction with services to parents/care-givers of the client
2. Pre-School: facility based program for children up to 5 years of age
3. Adult Development: facility based program for adults

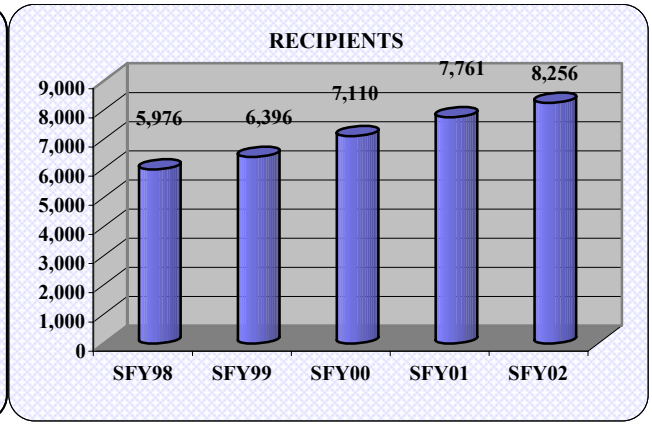
Optional Services available through DDTCS are as follows:
(Must be in conjunction with a core service)

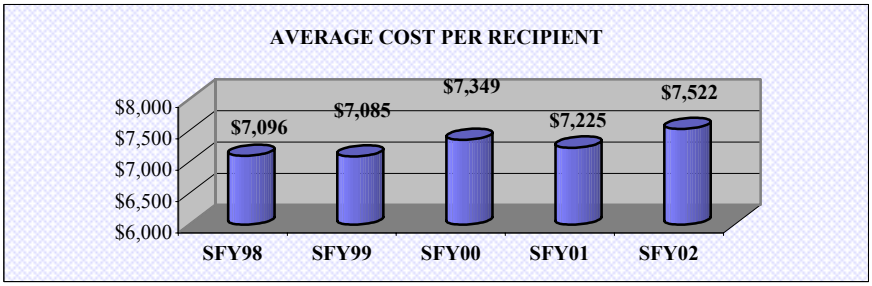
- physical therapy
- speech therapy
- occupational therapy
- therapy evaluations (PT, OT and ST)

Non-covered Services (not limited to):

- Adult Development Services, Pre-School Services and Diagnosis and Evaluation Services less than 1 hour
- Early Intervention Services less than 2 hours
- Supervised Living Services
- Educational Services
- Services to Inpatients







Source: DSS Reports; Medicaid Statistical Reports; Medicaid Provider Manual

MEDICAID FACTSHEET
CASE MANAGEMENT

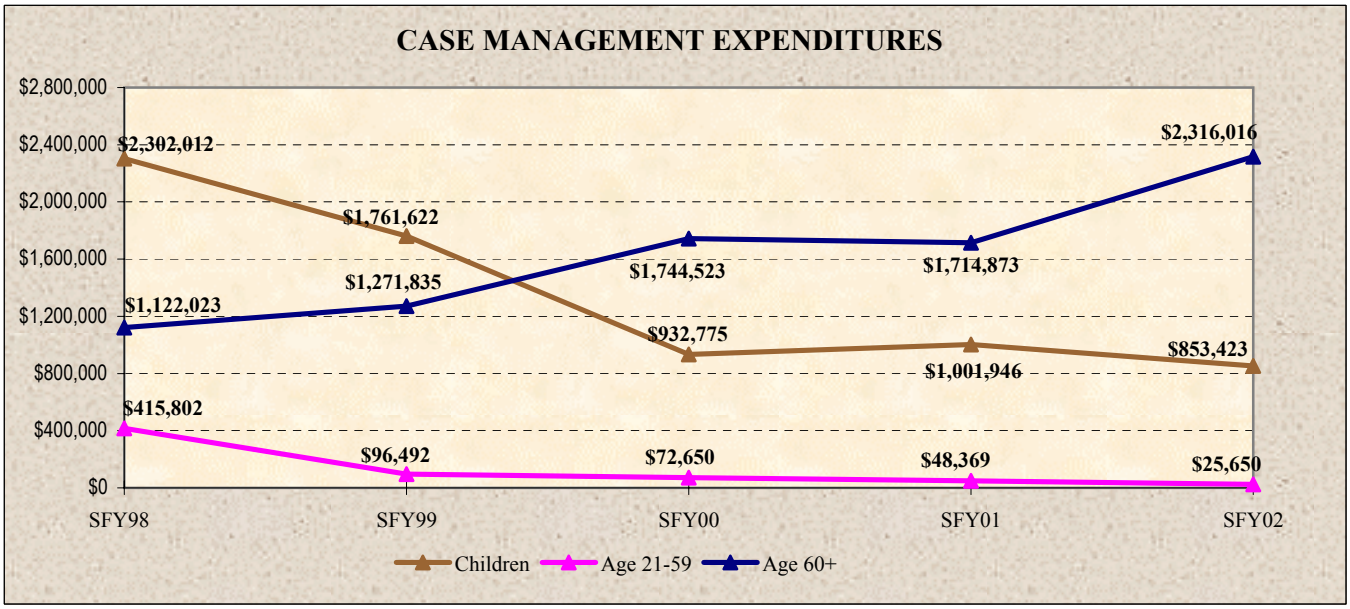
Case Management Expenditures
as % of Total Hosp/Med Exp:
SFY98: 0.43%
SFY99: 0.33%
SFY00: 0.27%
SFY01: 0.23%
SFY02: 0.21%

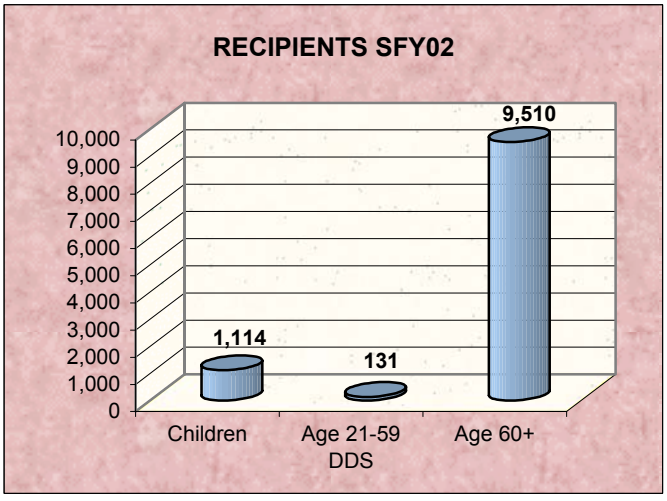
Case Management is designed to assist individuals in receiving necessary care and to coordinate services for those individuals. Recipients age 21 and older are limited to 208 hours of targeted case management services per fiscal year. There is no benefit limit for recipients under age 21.

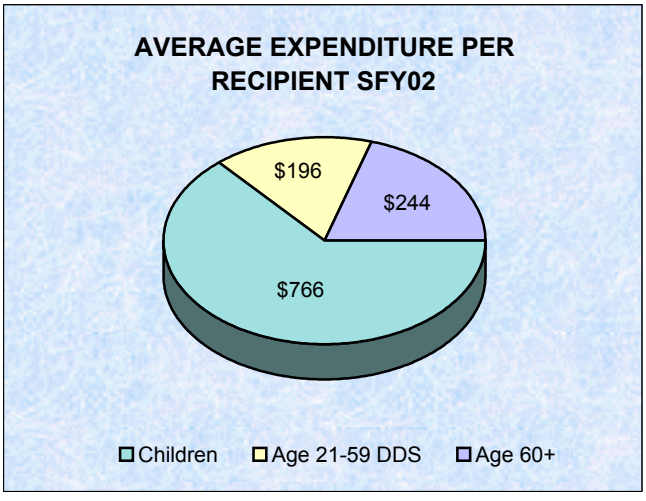
Case Management services are reimbursable when they are medically necessary, prescribed as the result of an EPSDT screen for recipients under age 21 ineligible for Developmental Disabilities Services, provided to recipients who have no reliable and available supports, and provided by a qualified provider enrolled to serve the recipient's targeted population. Case Management services to inpatients are not covered - inpatient facilities provide discharge planning.

Case Management is also reimbursable for:

* **individuals age 21 and younger eligible for Developmental Disabilities Services**
* **individuals age 22 and older with a developmental disability**
* **individuals age 60 and older who have limited functional capabilities resulting in the need for multiple services or who are not of mental capacity to understand their situation poses an imminent danger of death or serious bodily harm.**







Source: DSS Reports; Medicaid Statistical Reports; Medicaid Provider Manual

MEDICAID FACTSHEET
HOSPICE SERVICES

Hospice Expenditures
as % of Total Hosp/Med Exp:
SFY98: 0.34%
SFY99: 0.27%
SFY00: 0.29%
SFY01: 0.31%
SFY02: 0.34%

Definition:

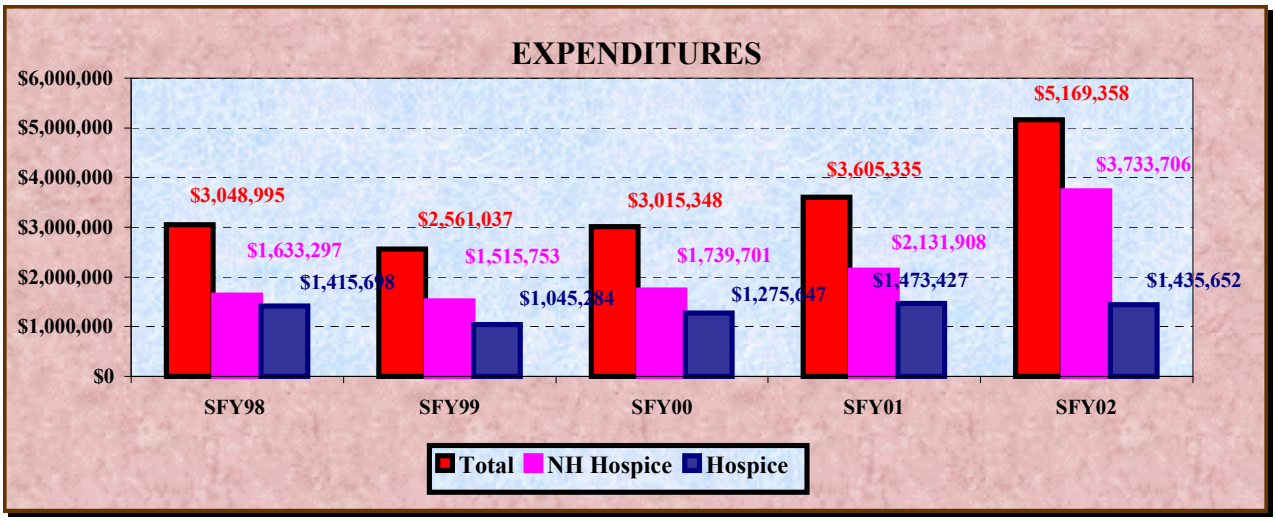
Hospice is a continuum of care, directed by professionals, designed to meet the needs & desires of those who are terminally ill & for whom curative medicine has exhausted its possibilities. Hospice services are reasonable & medically necessary services,

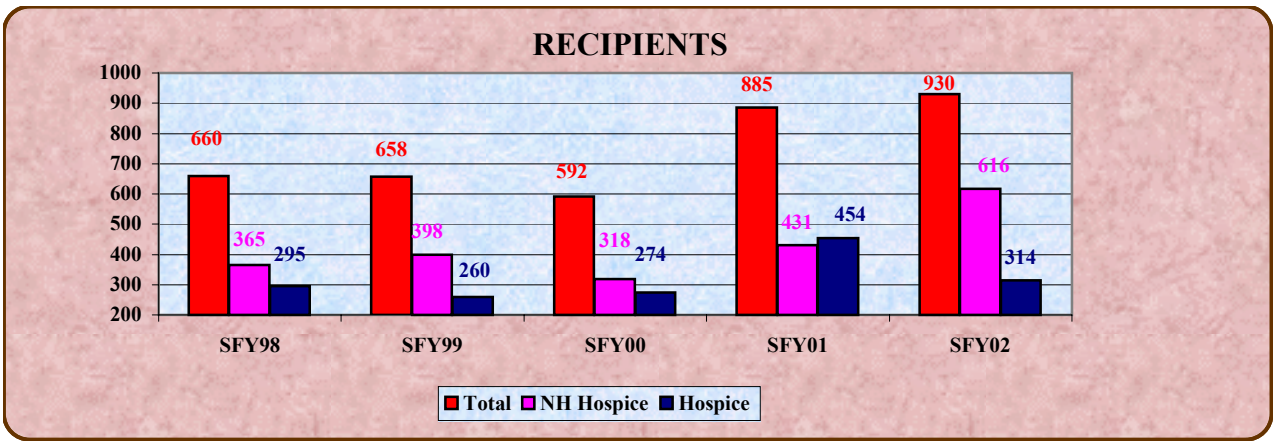
Eligibility:

* **Patients of all ages are eligible; Dual eligibles must reside in a Nursing Facility**
* **Patient must have terminal illness with life expectancy of six months or less**
* **Patients elect to receive hospital services instead of certain other Medicaid Benefits**
* **Hospice services must be provided primarily in patient's residence**

A patient may elect to receive hospice services in a nursing facility under specific agreement; or, in a hospital or nursing facility if the facility is an enrolled Medicaid Hospice provider. Hospice providers must have an interdisciplinary staff and volunteer assistants. Volunteer hours must be equivalent to at least five percent of the total compensated patient care hours.

Reimbursable Hospice Services: nursing care; social workers; physician services; counseling services to patient/family/care givers; medical appliances & supplies including drugs; home health aide services; certain physical, occupational & speech therapy services; continuous home care during crisis period; inpatient respite care; general inpatient care





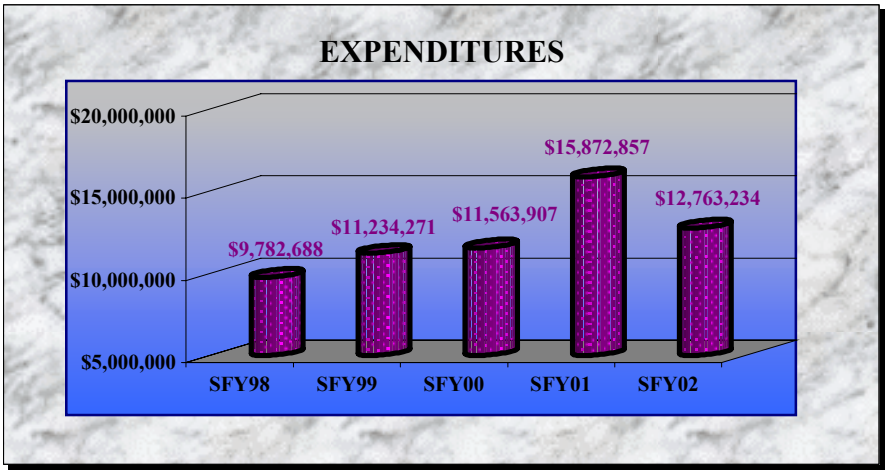
Source: DSS Reports; Medicaid Statistical Reports; Medicaid Provider Manual

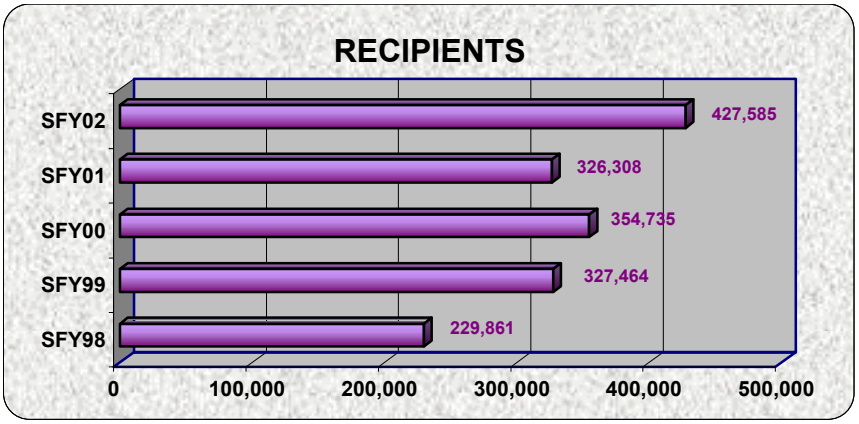
MEDICAID FACTSHEET
TRANSPORTATION

Transportation Expenditures
as % of Total Hosp/Med Exp:
SFY98: 1.09%
SFY99: 1.19%
SFY00: 1.15%
SFY01: 1.35%
SFY02: 1.08%

Non-Profit and Public Transportation is covered when the recipient is transported to or from a medical facility to receive covered services, when transportation is not otherwise available, for the least expensive available means suitable to the recipient's medical needs, to deliver individuals to the nearest qualified providers who are generally available and used by other residents of the community (unless the patient is referred by a physician to a provider that is outside of the general area).

If there is more than one recipient transported at the same time to the same location, Medicaid may be billed for only one recipient; if there is more than one recipient transported at the same time to different locations, the provider may bill only for the recipient traveling the farthest distance.





Source: DSS Reports; Medicaid Statistical Reports; Medicaid Provider Manual

MEDICAID FACTSHEET
MENTAL HEALTH SERVICES

Mental Health Expenditures
as % of Total Hosp/Med Exp:
SFY98: 13.59%
SFY99: 13.64%
SFY00: 13.18%
SFY01: 12.44%
SFY02: 12.86%

Mental Health Services are provided by Inpatient Psychiatric Facilities and Outpatient Services (RSPMI).

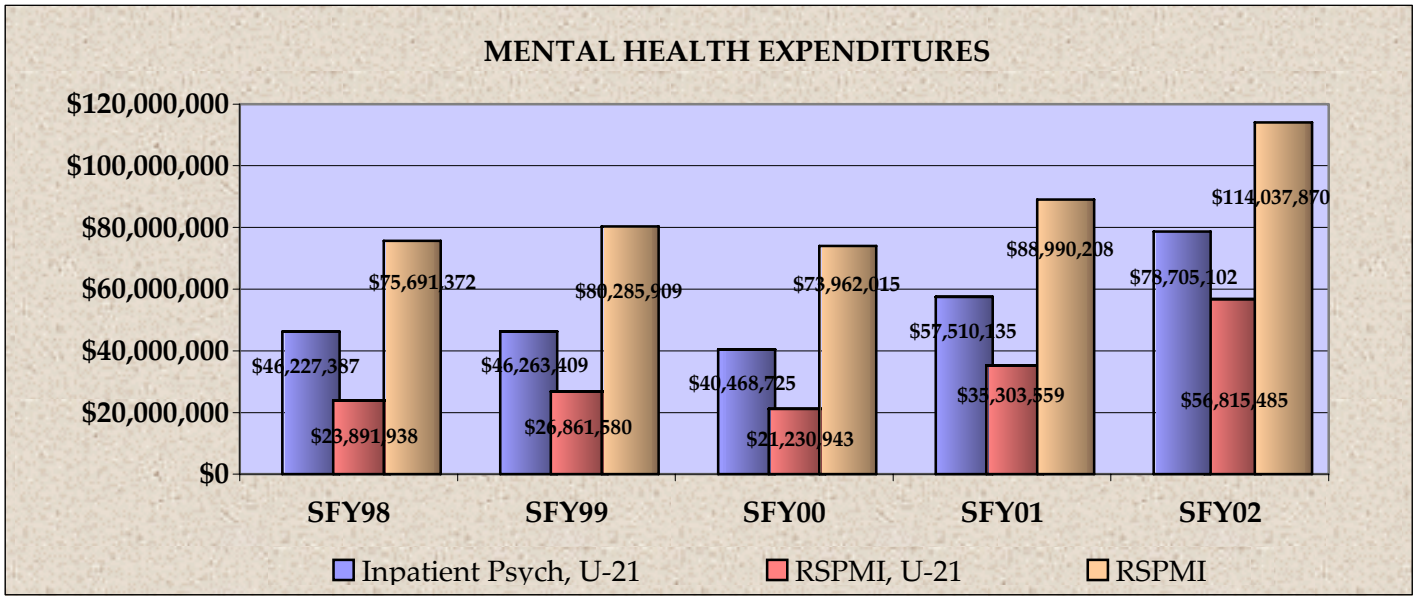
Inpatient Psychiatric Services are for recipients up to the age of 21; elective admissions require pre-certification by an independent certification team (First Mental Health, Inc., Nashville, TN).

Outpatient Services for Rehabilitative Services for Persons with Mental Illness (RSPMI) are provided by Community Mental Health Centers.

RECIPIENTS	SFY98	SFY99	SFY00	SFY01	SFY02
Inpatient Psych, U-21	3,155	3,442	3,226	4,015	4,898
RSPMI	24,787	27,436	28,692	33,723	40,517
Total	27,942	30,878	31,918	37,738	45,415

EXPENDITURES	SFY98	SFY99	SFY00	SFY01	SFY02
Inpatient Psych, U-21	$ 46,227,387	$ 46,263,409	$40,468,725	$57,510,135	$78,705,102
RSPMI	$ 75,691,372	$ 80,285,909	$73,962,015	$88,990,208	$114,037,870
Total	$ 121,918,759	$ 126,549,318	$114,430,740	$146,500,343	$192,742,973

RSPMI, U-21	SFY98	SFY99	SFY00	SFY01	SFY02
RECIPIENTS	12,080	13,407	14,080	18,831	24,902
EXPENDITURES	$23,891,938	$26,861,580	$21,230,943	$35,303,559	$56,815,485



Source: DSS Reports; Medicaid Statistical Reports; Medicaid Provider Manual; HCFA 2082

MEDICAID FACTSHEET
PSYCHOLOGIST SERVICES

Psychologist Svcs. Expenditures
as % of Total Hosp/Med Exp:
SFY98: 0.10%
SFY99: 0.09%
SFY00: 0.08%
SFY01: 0.09%
SFY02: 0.09%

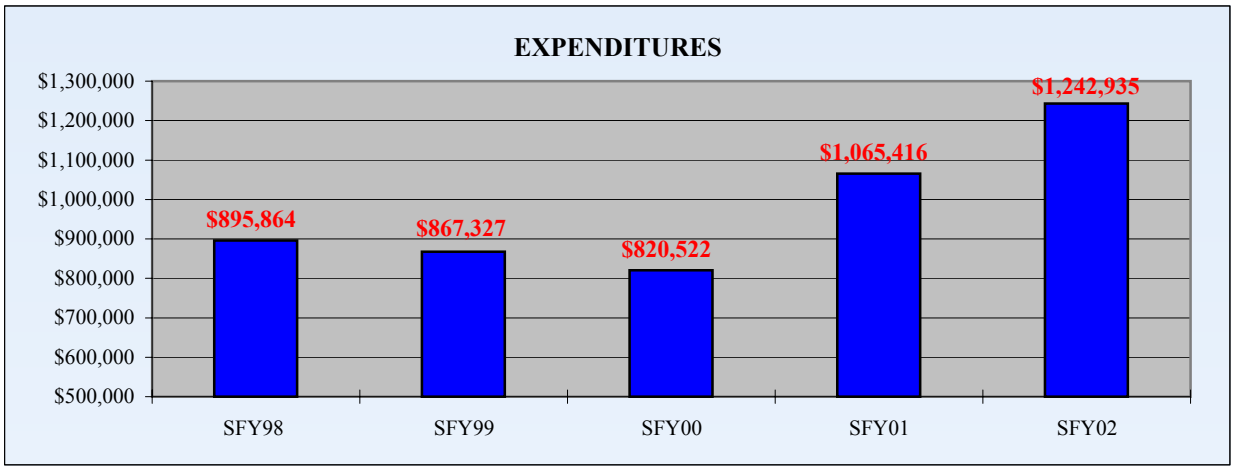
The Psychology Program consists of a range of mental health diagnostic, therapeutic, rehabilitative or palliative services provided by a licensed psychologist to Medicaid eligible clients **under the age of 21** who suffer from psychiatric conditions as described in the American Psychiatric Association Diagnostic and Statistical Manual (DSM III) and subsequent revisions.

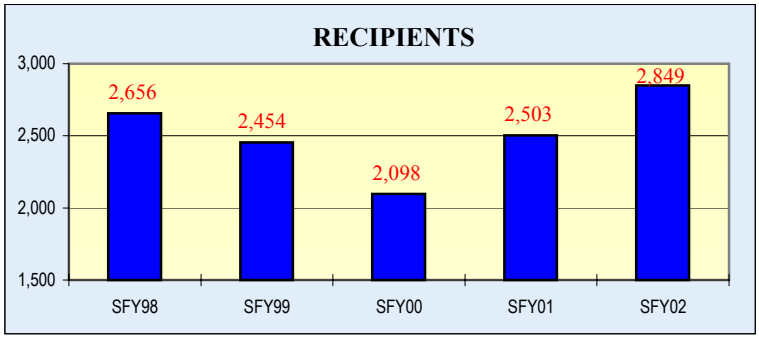
Covered Psychology Services:
* prescribed by a physician
* provided to outpatients
* provided by licensed psychologist
* when applicable, provided according to an Individualized Education Plan

Services covered when provided in:
* provider's office
* outpatient acute care hospital setting
* public school system setting under authority of Arkansas Department of Education

Psychology services are not available to inpatients. Psychologist may not bill for services provided in a Community Mental Health Clinic or an inpatient psychiatric facility (the individual facility must bill through their respective program).

Covered services include: diagnosis; psychological testing/evaluation; interpretation of diagnosis; crisis management visits; individual outpatient therapy sessions; marital/family therapy; group outpatient therapy.





Recipients by Age, SFY02:

Under 1	2
Ages 1 - 5	321
Ages 6 - 14	2,005
Ages 15 - 20	521

Source: DSS Reports; Medicaid Statistical Reports; Medicaid Provider Manual

MEDICAID FACTSHEET
PROSTHETICS/DME

Expenditures for Prosthetics/DME
as % of Total Hosp/Med Exp:
SFY98: 0.74%
SFY99: 0.94%
SFY00: 0.99%
SFY01: 0.97%
SFY02: 0.91%

Prosthetics Services are defined as durable medical equipment/oxygen, orthotic appliances, prosthetic devices, augmentative communication devices, specialized wheelchairs, wheelchair seating systems and specialized rehabilitative equipment. Prosthetics services may include any or all of these services.

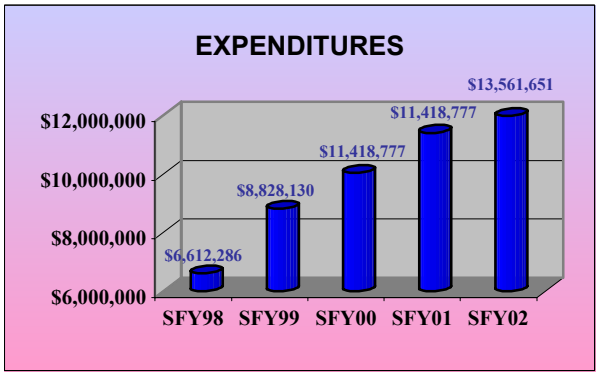
Services must be medically necessary and prescribed by the recipient's Primary Care Physician (PCP) unless the recipient is exempt from PCP requirements. Specified services are covered for recipients of all ages. Certain services are covered only for recipients under age 21 in the EPSDT Program. Where applicable, Prior Authorization is required.

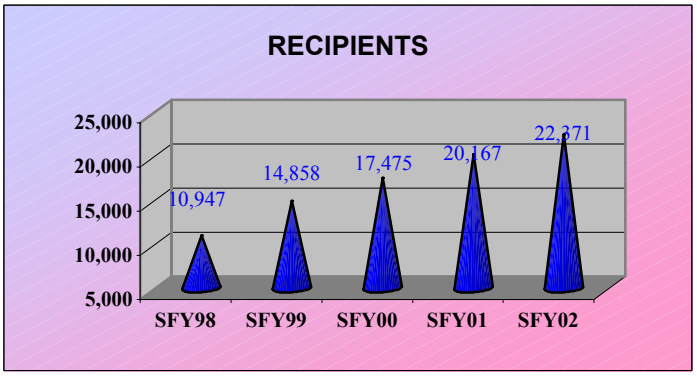
In order to be covered for services, a recipient's place of residence may not include a hospital, a skilled nursing facility, intermediate care facility or any other supervised living setting which is required to provide prosthetic services.

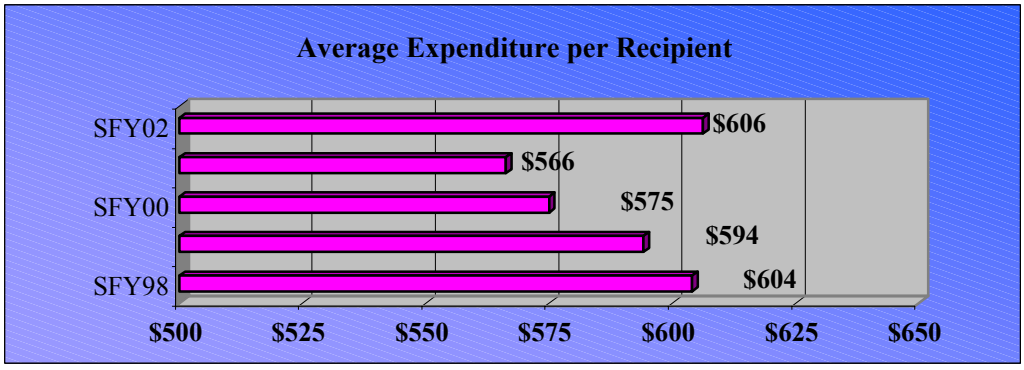
Non-Covered Services:

* Orthotic appliances and prosthetic devices for recipients over age 21
* Over-the-counter items provided through the Pharmacy Program
* Over-the-counter drugs
* Specialized wheelchair equipment which has ever been previously purchased for the recipient
* Wheelchairs for recipients under age 21 within two years of the purchase of a specialized wheelchair
* food stuffs; hyperalimentation

At least once every 6 months, the Primary Care Physician must certify medical necessity for prosthetics







Source: DSS Reports; Medicaid Statistical Reports; Medicaid Provider Manual

MEDICAID FACTSHEET
THERAPY SERVICES

Therapy Services Expenditures
as % of Total Hosp/Med Exp:
SFY98: 1.74%
SFY99: 1.85%
SFY00: 2.05%
SFY01: 2.18%
SFY02: 2.14%

***** Therapy Services encompass Physical Therapy, Occupational Therapy, and Speech Pathology Services *****

Therapy Services provided according to physician referral to Medicaid eligibles under age 21 under the EPSDT Program

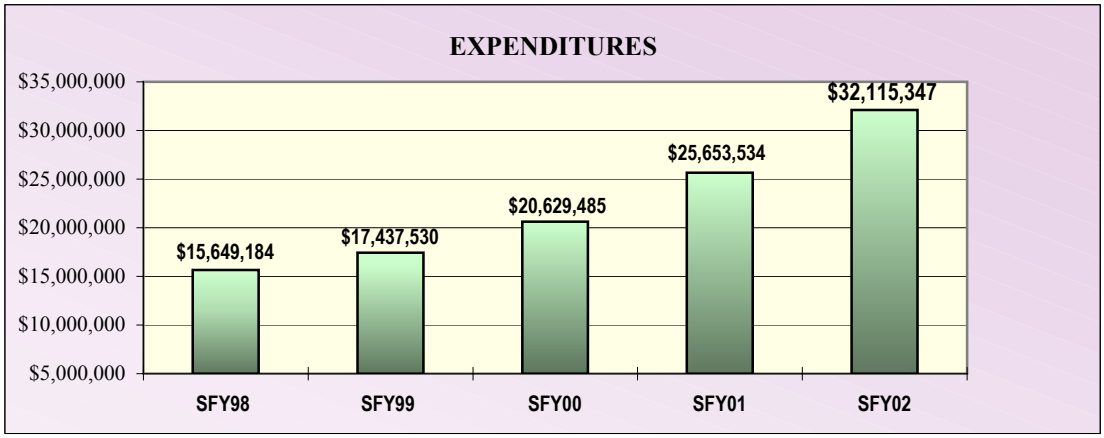
Individuals who have been admitted as an inpatient to a hospital and/or are residing in a nursing care facility are not eligible for occupational therapy, physical therapy, and speech pathology services under this program. Prior authorization is required for therapy services.

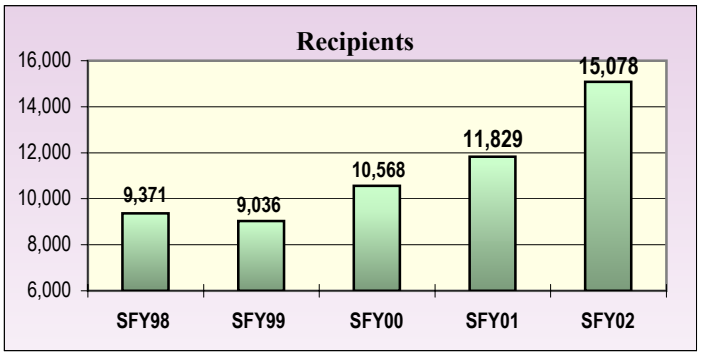
Scope of Therapy Services: *Services covered only when these conditions exist…*

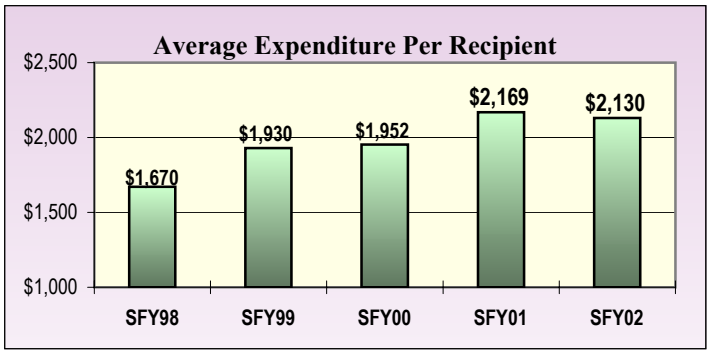
1. Services provided by appropriately licensed individuals enrolled as Medicaid providers.
2. Services provided as a result of a referral from the recipient's PCP or attending physician.
3. Treatment services must be provided according to a written prescription signed by the recipient's PCP or attending physician.
4. Treatment services must be provided according to a treatment plan or plan of care for the prescribed therapy.

Therapist Counts SFY02	*Physical Therapists*	*Occupational Therapists*	*Speech Pathologists*
Individual Therapists	494	381	721
Group Therapists	416	332	391
School Therapy	89	83	174

Recipient Counts (counts are duplicated between categories) : SFY 02	
Physical Therapy	7,466
Occupational Therapy	3,098
Speech Therapy	8,023







Source: DSS Reports; Medicaid Statistical Reports; Medicaid Provider Manual

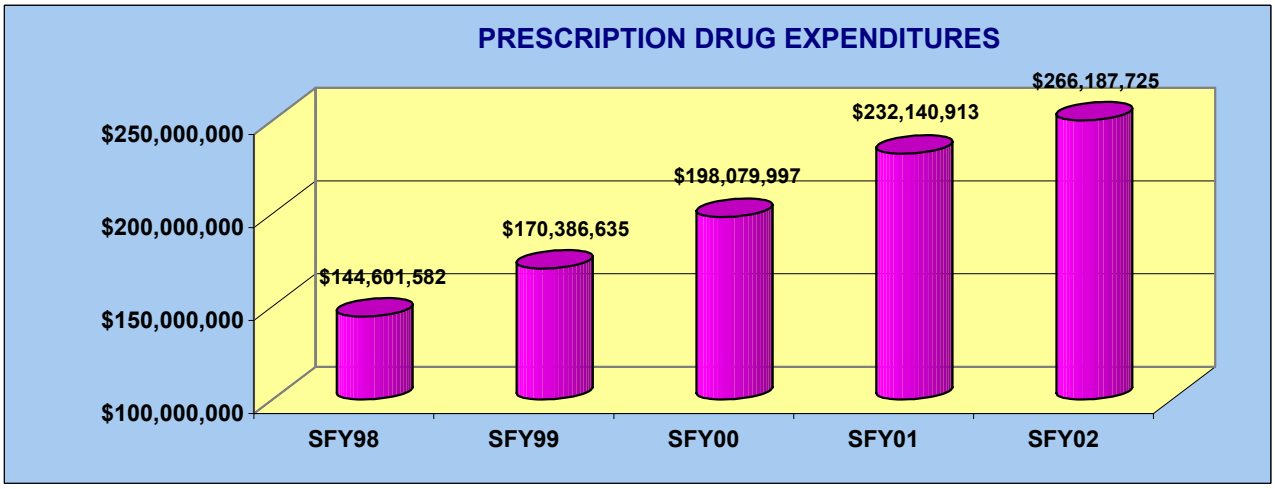
MEDICAID FACTSHEET
PRESCRIPTION DRUGS

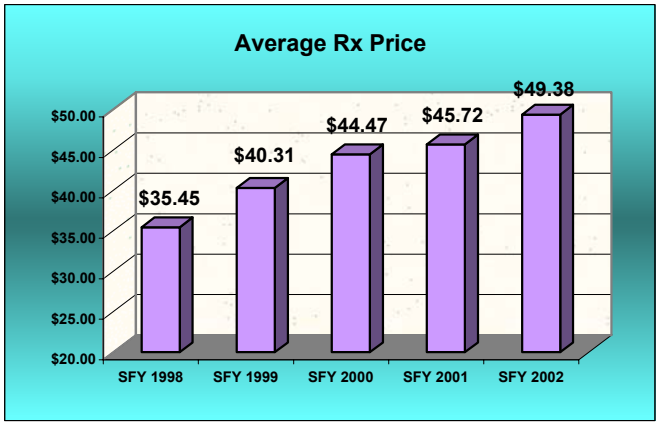
Rx Drug Expenditures as % of Total Hosp/Med Exp:
SFY98: 16.12%
SFY99: 18.06%
SFY00: 19.68%
SFY01: 19.71%
SFY02: 17.76%

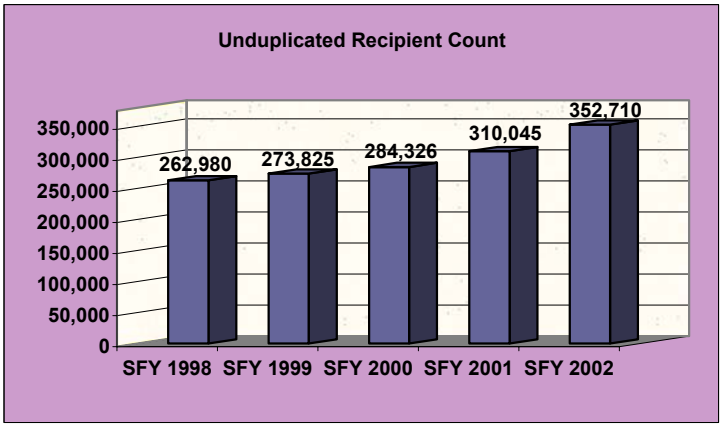
Three prescriptions per recipient per month (extensions possible); family planning items do not count against limit. No limit for children under 21 (EPSDT) and certified nursing home residents.

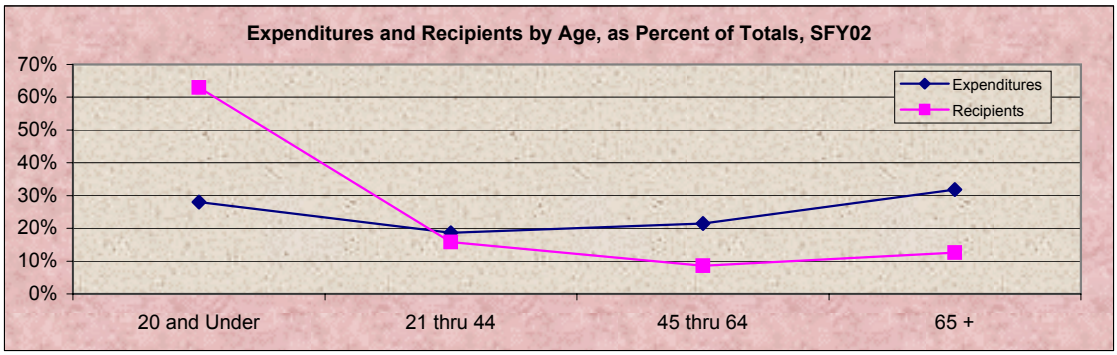
757 Participating Pharmacies available to Medicaid recipients in SFY 02.

Medicaid Drug Rebate Program created by OBRA, 1990 - law requires that Medicaid reimburse only for drugs manufactured by pharmaceutical companies that have signed rebate agreements. Approximately 670 drug companies participate. The Rebate Program gives Medicaid the equivalent of large volume purchasing advantages.









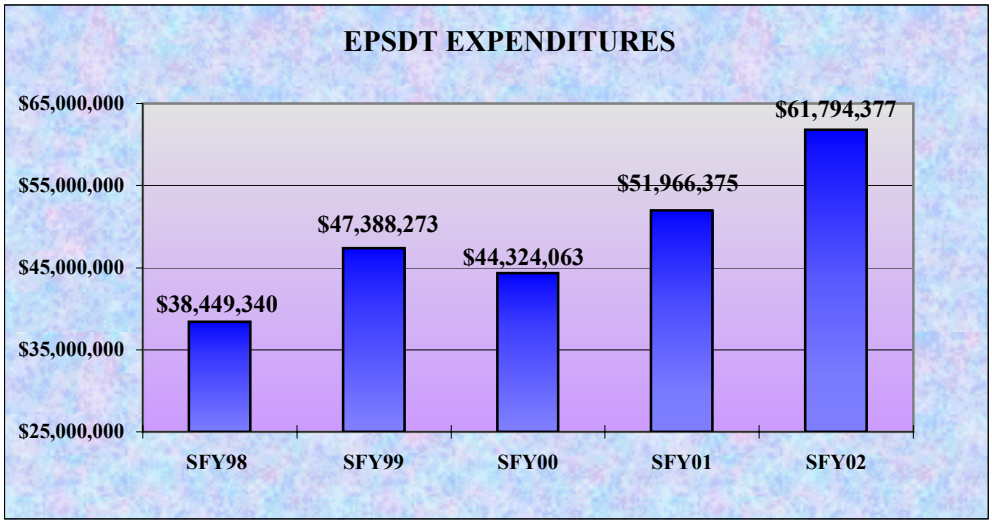
MEDICAID FACTSHEET
EPSDT

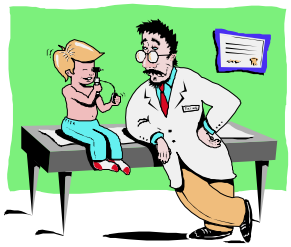
EPSDT Expenditures
as % of Total Hosp/Med Exp:
SFY99: 5.02%
SFY00: 4.40%
SFY01: 4.41%
SFY02: 4.12%

The Child Health Services Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program is a federally mandated child health component of Medicaid. EPSDT is designed to ensure comprehensive health care to individuals under the age of 21 (even if the individual is a parent) who are eligible for rmedical assistance. Arkansas' medical periodic screening schedule follows the American Academy of Pediatrics recommendations. Health professionsals who do EPSDT screenings may diagnose and treat health problems identified during the screening or may refer the child to other sources of care. Treatment for conditions discovered during a screen may exceed limits of the Medicaid Program.

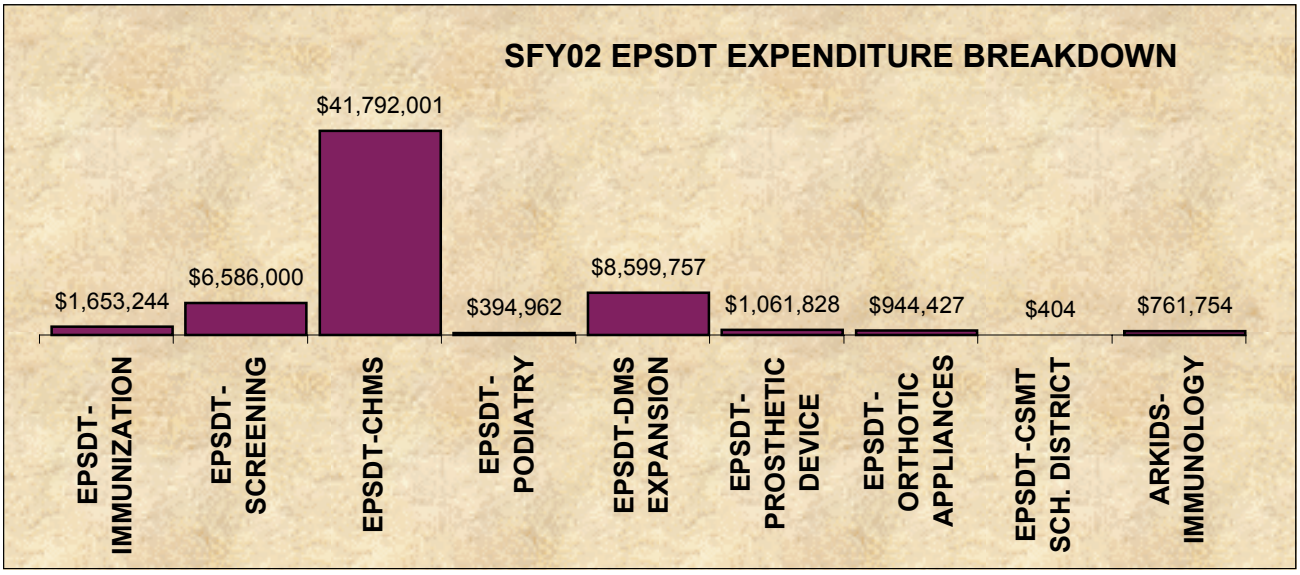
Screening Components

Health and developmental history, physical examination, developmental assessment, visual and hearing evaluations, dental health assessment, blood lead testing, nutritional assessment, and health education.





155,688 Recipients
SFY02



Source: DSS Reports; Medicaid Statistical Reports; Medicaid Provider Manual

Number of consumers served and costs of services in various Arkansas Rehabilitation Services programs

Program	Case costs per fiscal year							
	1998		1999		2000		2001	
	Number	Costs	Number	Costs	Number	Costs	Number	Costs
VR	19,578	$17,532,558	22,479	$21,101,403	22,822	$20,609,584	23,322	$21,332,284
HSRC	1,032	$13,409,610	842	$12,010,507	847	$13,019,511	902	$13,558,655
ODHI-VR	1,497	$2,792,280	1,171	$2,871,353	1,380	$3,063,584	670	$1,889,005
Title VII-IL Services	--	--	730	$554,236	732	$554,236	670	$554,236
Supported Employment	101	$245,410	246	$298,919	250	$474,450	248	$227,990
CRPs	1,328	$1,382,661	1,284	$1,334,005	1,355	$1,342,674	1,338	$1,320,874
ACES	--	--	116	$489,246	234	$712,663	271	$633,364
ICAN	4,434	$876,777	2,791	$367,878	1,447	$308,629	1,707	$377,393
CADET	--	--	--	--	--	--	96	$216,183

Arkansas Rehabilitation Services Program Descriptions

Vocational Rehabilitation (VR). Arkansas Rehabilitation Services provides vocational rehabilitation services to Arkansans with mental, physical and sensory disabilities to enable them to obtain and keep meaningful jobs. Services include counseling and evaluation to ensure a client's strengths are identified and maximized, physical restoration and medical services to prepare clients physically, academic and vocational training to obtain high quality jobs commensurate with their aspirations and abilities, and the equipment to ensure clients are adequately prepared to enter the workplace.

Hot Springs Rehabilitation Center (HSRC). HSRC is a unique facility offering a range of comprehensive services to Arkansans with disabilities. The Center offers two core programs: the Arkansas Career Training Institute and the Hot Springs Rehabilitation Hospital.

Office of Deaf and Hearing Impaired (ODHI-VR). ODHI provides vocational rehabilitation services to Arkansans who are deaf or hearing impaired. Services provided are as listed above for VR.

Office of Deaf and Hearing Impaired Independent Living Services (Title VII-IL Services). This program provides independent living services to Arkansans who are Deaf or Hearing Impaired. Services include training and assistive devices intended to make the individual more independent in the activities of daily living.

Supported Employment. Supported employment services, including a job coach, are provided to individuals with a disability to assist them in gaining and keeping competitive jobs at or above the minimum wage. This service is available through a network of non-profit providers.

Community Rehabilitation Programs (CRPs). CRPs provide assessment/evaluation, work adjustment and extended services training for Arkansas Rehabilitation Services referred consumers in a vocationally relevant work oriented environment. The program provides basic employability/job readiness skills training, independent living skills training, transportation services, supervised off-site mobile work crews, work enclaves, target specific vocational training, and direct job placement assistance. These services are provided through a statewide network of community providers.

Arkansas Consortium for Employment Success (ACES). ACES is a system change grant program funded by the Rehabilitation Services Administration, U.S. Department of Education OSERS). This program works with the Social Security Administration to provide vocational rehabilitation services to individuals who have applied for Social Security Disability Insurance in an effort to divert them to employment before they begin to receive benefits. TANF recipients are also eligible to participate in this program.

Increasing Capabilities Access Network (ICAN). The Increasing Capabilities Access Network provides activities that assist the State in maintaining and strengthening a permanent, comprehensive statewide program of technology-related assistance for individuals with disabilities of all ages. Services include capacity building, advocacy, information/referral, outreach, public awareness, training, demonstrations, used equipment exchange and equipment loan programs.

Telecommunications Access Program (TAP). This program provides access to telecommunications equipment to eligible Arkansans who are deaf, hard of hearing, or speech impaired or who have any other disability that prevents them from accessing the telecommunications system.

Low Interest Loan. A low interest loan fund was established in 1989 to assist individuals with a disability to purchase assistive technology. The original fund was used as match for a federal grant in 2002 to expand the fund to $1.6 million. The new, expanded loan fund is called the Arkansas Assistive Technology Alternative Financing Program.

Creative Alternatives for Delta Area Transportation (CADET). CADET is a $1,375,000 grant over five years to provide transportation services to people with disabilities in the Delta area to assist them in preparing for, obtaining and maintaining employment as well as to enhance and expand the transit system for the future.

Institutional Services Counts and Cost

Type of Facility	Midnight Census Count 06/30/02	SFY02 Unduplicated Recipient Count	SFY02 Incurred Expenditure Cost
Nursing Homes	12,898		$368,316,025.12
Arkansas Health Center	304		$22,743,822.81
Human Development Centers	1,161	1,238	$84,508,060.44
Pediatric Facilities	197	240	$16,972,946.39
Ten Bed	343	393	$20,402,546.03
Total:	14,903	1,871	$512,943,400.79

Type of Facility	Midnight Census Count 06/30/01	SFY01 Unduplicated Recipient Count	SFY01 Incurred Expenditure Cost
Nursing Homes	13,375		$292,638,298.42
Arkansas Health Center	301		$21,265,038.39
Human Development Centers	1,215	1,283	$86,833,541.91
Pediatric Facilities	202	243	$16,211,380.57
Ten Bed	356	387	$20,432,125.58
Total:	15,449	1,913	$437,380,384.87

Type of Facility	Midnight Census Count 06/30/00	SFY00 Unduplicated Recipient Count	SFY00 Incurred Expenditure Cost
Nursing Homes	13,840		$274,454,763.60
Arkansas Health Center	309		$22,601,655.76
Human Development Centers	1,231	1,284	$89,454,381.86
Pediatric Facilities	202	240	$15,595,926.30
Ten Bed	360	1,524	$20,325,453.37
Total:	15,942	3,048	$422,432,180.89

Type of Facility	Midnight Census Count 06/30/99	SFY99 Unduplicated Recipient Count	SFY99 Incurred Expenditure Cost
Nursing Homes	14,206		$259,598,275.45
Arkansas Health Center	319		$21,554,688.94
Human Development Centers	1,231	1,266	$85,384,910.62
Pediatric Facilities	202	233	$14,171,512.01
Ten Bed	358	383	$19,517,929.16
Total:	16,316	1,882	$400,227,316.18

Type of Facility	Midnight Census Count 06/30/98	SFY98 Unduplicated Recipient Count	SFY98 Incurred Expenditure Cost
Nursing Homes	14,445		$269,199,067.57
Arkansas Health Center	331		$23,624,942.56
Human Development Centers	1,244	1,306	$81,589,853.85
Pediatric Facilities	186	215	$12,948,750.61
Ten Bed	355	390	$19,405,647.24
Total:	16,561	1,911	$406,768,261.83

Appendix B

GIST Recommendations

FINANCING COMMITTEE MECHANISMS RECOMMENDATIONS

1. 20 For 1 Against Use existing funding efficiently and effectively. Use State general revenue to leverage Medicaid federal funds when possible. DHS will work with its divisions and other state agencies providing services to people with disabilities (Health Department, Rehabilitation Services, Spinal Cord Commission, etc.) to determine whether state-funded programs can be incorporated into Medicaid programs to take advantage of federal matching funds. The review should include analysis of the number of people who can be served and the value of their benefits as state-funded programs versus Medicaid waiver programs. (Adopted by GIST, 2-4-02)

2. 19 For 3 Against GIST Review of DHS Budget Proposal.
Request copies of the preliminary and final Priority Requests and Briefing Packets for DHS for the 03-05 Biennium Budget.

A. Request copies of the schedule for the Biennium Budget Cycle.
B. Propose specific priority requests.
C. Request that DHS allow the GIST to review proposed Special Language and legislative initiatives.
D. Request monthly updates on waiting lists for institutions and waiver services. (Adopted by GIST, 3-4-02)

3. 19 For 1 Against Restructure DDS funding to meet consumer and family needs. DHS, in coordination with the Governor's Office and the DDS Board, should address restructuring all available DDS funding streams to allow maximum flexibility to utilize all available dollars to meet the needs of the population in accordance with consumer and family choice and direction.

4. 21 For 0 Against Restructure mental health service delivery.
DHS, in coordination with the Governor's Office and the Arkansas Mental Health Planning and Advisory Council, should address restructuring the Mental Health service delivery system including building smaller facilities (less than 16 residents) to enable accessing of Medicaid funding streams.

5. 19 For 1 Against Use existing housing funds to finance integrated housing and community facilities. Arkansas Development Finance Authority (ADFA) should help meet the housing needs of people with disabilities, through Section 8 rental subsidies, and by providing financing for developers of integrated housing and community facilities through the Home Investment Partnerships Program (HOME), Community Development Block Grant (CDBG) program, and low-income housing tax credit financing.

6. 18 For 2 Against Reward housing developers who incorporate universal design. Arkansas Development Finance Authority (ADFA) should award extra points to proposals from developers who incorporate universal design into their projects.

7. 18 For 2 Against Reduce use of institutional care, which is not integrated and generally costs more than home and community supports and services. Provide information to applicants about alternatives to institutionalization. All long-term care institutions (private and public nursing homes, human development centers, and ICF/MRs) will provide each applicant, including those who are private pay, with a packet of information prepared by DHS about alternatives to institutional care. (Adopted by GIST, 2/4/02)

8. 16 For 3 Against Reduce admissions through independent eligibility assessment and choice of alternatives. Medical eligibility for Medicaid-covered institutional level care will be assessed uniformly for applicants and clients in both institutional and community settings. Medical eligibility assessments will be conducted face-to-face by teams of at least two assessors who are not affiliated with the institution or a provider to avoid any conflict of interest. Teams will assess people in both institutions and community settings, for initial assessments and all periodic reassessments.

If possible, applicants for institutional care (public and private nursing homes, human development centers, and ICF/MRs) will be assessed prior to admission to a facility. The assessors will be professionals, such as registered nurses, rehabilitation counselors, or social workers, who have experience working with the client group and are familiar with community supports and services. Assessors will be tested for reliability. Assessors will advise the client or guardian about their support and service options at initial assessments and each reassessment, and allow them to make an informed choice.

9. 19 For 2 Against Transitions from Human Development Centers to community. Identify Human Development Center residents appropriate and willing to transition to community placements, and develop the necessary flexibility with respect to services and supports to facilitate transition to community settings. Guarantee the option of returning to the HDC if the community placement is unsuccessful.

10. 16 For 4 Against New Roles for the Human Development Centers
As residents are transitioned out of the Human Development Centers, the HDC's should assume new roles such as providing quality assurance for home and community services, and providing services such as diagnosis, short-term treatment, community placement, and respite care.

11. 21 For 0 Against Continue the Passages program to help resident's transition to community. Continue the Passages program to help residents of institutions move back into the community by providing case management, access to Medicaid services, and assistance with the costs of housing and setting up a household.

12. 21 For 0 Against Improve access to cost-effective home and community-based services by making them as easy or easier to access as institutional services. Reduce waiting lists for home and community waivers.
Identify all waiver waiting lists and project future needs. Set timeline to steadily reduce waiting lists.

13. 20 For 1 Against Reduce response times for obtaining home and community services. The State should reduce the time necessary to access community services to equal that required to access institutional services.

14. 18 For 3 Against Improve access of underserved groups through amended or new waivers. DHS should amend current Medicaid waivers or create new waivers to better serve those individuals not receiving adequate care. Existing programs using general revenues to serve these populations could be a potential source of matching funds. Program development should consider the special needs of these and other groups:

A. Catastrophic care waiver for very high need clients (e.g., quadriplegic, ventilator dependent, dual diagnosis) with cost-neutrality based on comparison to the Benton Services Center.

B. Individuals with traumatic brain injuries, end stage renal disease, children and adults with cognitive disabilities and behavioral needs, medically fragile children and adults (spina bifida, CF, chronic health issues), deaf-blind persons, and other underserved populations with functional impairments.

15. 17 For 2 Against Fully fund the Developmental Disability waiver and increase flexibility. Arkansas should fund the Developmental Disabilities Services waiver waiting list. The DDS waiver should be fully funded to address the waiting list and the caps that prevent this waiver from being an alternative to HDCs and ICF/MRs. The $160 a day cap on direct care services should be eliminated.

A. If the cap cannot be eliminated, then the rate should be adjusted upward to reflect cost of living increases over the past nine years; and

B. The method of computing when the cap is reached should be changed to reflect the annual cost of service. This would:

i. eliminate bias against working families;

ii. increase family flexibility;

iii. save State general revenue and Social Services Block Grant dollars.

16. 20 For 1 Against Reduce eligibility age for Alternatives waiver from 21 to 18 years. DHS, Division of Adult and Aging Services should change the eligible age for services from 21 to 18 years for the Alternatives Waiver.

17. 16 For 4 Against Review and adjust Medicaid rates for home and community services. Medicaid reimbursement for home and community services should be reviewed at least every two years, and rates should be adjusted to insure that providers can hire and retain good workers by offering competitive pay and benefits.

18. 21 For 0 Against Address issues related to Nurse Practice Act.
DHS and others should work with the State Board of Nursing to insure that the Nurse Practice Act is not a barrier to providing care in the community.

19. 19 For 2 Against Identify and eliminate institutional bias.
DHS should identify and eliminate institutional bias in Medicaid long-term care eligibility, services, and reimbursement.

20. 21 For 0 Against Speed-up access to waivers with Fast Track process.
Develop and implement a Fast Track eligibility process for Medicaid waiver programs.

21. 20 For 1 Against Review criteria for institutional care and waivers.
DHS should review criteria for institutional care [which are also the criteria for waiver eligibility] to insure that they are fair, consistent, reliable, clearly stated and easy to interpret, and do not exclude persons with some disabilities or medical conditions [e.g., non-DD adults with cognitive impairment].

22. 20 For 1 Against Insure that home and community services meet the needs of people with severe disabilities, so they can successfully live in the community. Increase consumer direction for waiver and State Plan services.
Amend the waivers and home and community services in the Medicaid State Plan to include more consumer direction of services, and a cash and counseling option that enables consumers to obtain appropriate supports and services that best meet their needs.

23. 17 For 4 Against Equalize access to services between community and institutions. Community-based services should be expanded to include all services (e.g., prescriptions, dental) that an individual requires to maintain community placement. The menu of service options should never be less than what is available in institutions for comparable population.

24. 13 For 8 Against Remove benefit limits within waivers.
DHS should consider removing all caps within existing waivers. Given existing restraints on the total cost of a waiver plan of care, caps on the components that make up the waiver are unnecessarily restrictive. Specifically, caps on technology/equipment limit an individual's options to trade technology for other services even when the technology may reduce the need for other services.

25. 14 For 7 Against Require providers to have back-up caregivers for “no shows”. DHS contracts should include a requirement that providers must have back-up personnel to serve clients when regularly scheduled staff is a “no shows.”

26. 18 For 3 Against Restructure DDTCS to be more flexible.
Restructure DDTCS [community provider] programs to become more flexible in providing home and community-based services with more consumer direction and less center-based.

27. 16 For 3 Against Develop more options for school age children with disabilities. DHS, in partnership with the Department of Education, needs to develop options for school age children with disabilities that can be accessed during the summer months and other times when school is not in session.

28. 15 For 4 Against Pilot use of community boards. DHS divisions should pilot the use of community boards as a means of pooling resources and adding consumer direction.

29. 14 For 6 Against Increase integration into the community at all levels.
Integrate DDTCS pre-school day care. Restructure DDTCS pre-school day care so that a minimum of 50% non-disabled children is served. Families should have the ability and option to choose any integrated day care.

30. 19 For 0 Against State agencies should develop plans to integrate community facilities. State agencies, including the Department of Education, which serve people with disabilities and pay for services or operate community facilities or programs such as day treatment, sheltered workshops, or educational programs, should develop plans, with public input, to increase opportunities for programs and services to be provided in integrated settings.

31. 20 For 0 Against Arkansas Rehabilitation Services should set standards for meaningful work and compensation. ARS should set standards for employment programs to provide more meaningful work and compensation, including seeking private sector employment.

32. 18 For 2 Against Improve quality of life in institutions.
Improve quality of life in institutions through strategies to increase community integration, and/or encourage home-like living arrangements, such as the "Eden Alternative".

33. 19 For 1 Against Develop new, non-tax resources. Grants for Olmstead implementation. The State should make a concerted effort to apply for federal and private grants that will enhance the goals of implementing the Olmstead decision. Consumers should be involved in development of grant applications.

34. 17 For 3 Against Promote volunteer care giving programs
The State should encourage volunteer programs that mobilize people to help provide care in the community, such as the *Faith In Action* projects that encourage congregations to sponsor care giving programs. Churches and other non-profits should also be encouraged to play a greater role in developing and operating housing and long-term care facilities.

35. 19 For 1 Against Encourage increased private spending on long-term care.
Group long-term care insurance for State employees. The State of Arkansas should offer high quality, high benefit group long-term care insurance to all state employees as an employee benefit. Employees would pay the full premium. Group long-term care is much less expensive to employees than individual policies, encouraging people to plan ahead for long-term care costs. It also enables spouses and possibly other family members to buy policies at a reduced price. The State benefits by providing an attractive benefit at little cost, and by reducing its future Medicaid long-term care costs.

36. 19 For 2 Against Promote group long-term care insurance among private employers. The State should encourage private employers to provide group long-term care insurance to their employees, as a means of lowering premiums for employees, thereby increasing coverage and reducing future long-term care costs to the State

37. 19 For 2 Against Develop strategies to reduce future demand for long-term care. Risk factors for acquired disabilities and institutionalization.
DHS should identify risk factors that lead to acquired disabilities and institutionalization and identify which populations are at greatest risk. For example, among the elderly, factors may include noncompliance with prescription drugs, fall hazards in the home, lack of caregiver support, malnutrition, and muscle atrophy due to inactivity. Programs should be developed to reduce or postpone acquired disabilities and institutionalization.

38. 15 For 5 Against Develop a database of long-term care applicants and consumers to collect data to improve management decision-making and program design. DHS should develop and maintain a database of applicants and consumers of Medicaid long-term care, including financial data, and medical conditions, to help determine the impact of proposed policies. An advisory committee should be formed to help determine data needed and make sure clients' confidentiality is protected.

39. 20 For 0 Against To measure the cost of transition.
Determine the average cost of transitioning institutional residents back into the community, either through a pilot project or by reviewing cases from the Passages program and other case-managed transitions.

LONG-TERM CARE WORKFORCE

40. 21 For 0 Against. Develop a reliable payroll system for consumer-directed workers, so workers will be paid in a timely manner and consumers will not be left without care.

41. 16 For 4 Against All Medicaid provider agencies should withhold payroll taxes and Social Security from their employees' paychecks. Medicaid is funded by state and federal tax dollars and it is bad public policy to allow some providers to routinely avoid withholding taxes. This practice also raises questions about whether the employers can meet both supervision requirements and the IRS test for independent contractors. Employing home care attendants as "independent contractors" also jeopardizes the employees' Social Security retirement and disability benefits.

42. 17 For 4 Against. Medicaid should reimburse providers of home and community services for training of attendants, as they reimburse nursing facilities for aide training.

43. 20 For 0 Against Request that the Department of Finance and Administration research the possibility of private non-profit provider agencies participating in state health insurance and retirement programs, with provider agencies collecting and paying the employer and employee contributions.

NOTHING ABOUT ME WITHOUT ME

44. 16 For 5 Against. The Medicaid Advisory Board needs to be Governor-appointed and include Medicaid consumers and consumer representatives.

LEGISLATIVE RECOMMENDATIONS

45. 14 For 7 Against The GIST encourages the Governor and the Legislature to consider using the Tobacco Settlement Trust Funds as a partial source of temporary assistance to Medicaid. (Adopted by GIST, 1-7-02)

46. 20 For 1 Against The GIST encourages the Arkansas Congressional delegation to seek a temporary 10% increase in the federal Medicaid match rate. (Adopted by GIST, 1-7-02)

47. 14 For 6 Against The General Assembly should not renew special language in the DDS/DHS Appropriations Bill limiting any new, willing provider or excluding new, willing providers of developmental disability services.

48. 15 For 5 Against Eliminate the Health Services Permit Commission and Agency.

49. 18 For 0 Against The General Assembly should enact mental health parity legislation, to require health insurers to cover mental health care as they cover treatment of physical illnesses. [The federal ERISA law probably exempts employer-sponsored health care plans, so a majority of workers may not be affected]

50. 19 For 2 Against The GIST encourages the Arkansas Congressional delegation to support an increase in Social Services Block Grant (SSBG) funding from $1.7 Billion to at least $2.38 Billion. SSBG is a vital source of funding for services to the most vulnerable individuals in our state —
low-income children, elderly, and people with disabilities, and victims of abuse and neglect.

ACCESS & ELIGIBILITY RECOMMENDATIONS

These recommendations are gleaned from the Olmstead Task Force Access & Eligibility Committee Report and do not appear to have been covered by any GIST Committee:

51. 19 For 1 Against DHS should allow provider agencies to hire consumers' family members to provide Medicaid in-home services under the same conditions as family members can be hired for IndependentChoices. Hiring of family members should also be extended to waiver services.

52. 19 For 2 Against Arkansas Medicaid conducted a successful marketing and enrollment campaign for ARKids First. Some of the approaches utilized in the ARKids First program should be utilized in Medicaid programs for people with disabilities, to inform people about the programs and make eligibility determination more user-friendly.

53. 16 For 4 Against Medicaid asset limits should be adjusted, especially for persons with disabilities who are unable to work and acquire assets. Homeowners living in their homes should be allowed at least $10,000 in savings for contingencies, such as replacing their roof or furnace. Non-homeowners living in the community also need savings to pay for car/van repairs or replacement, prescriptions not covered by Medicaid, etc.

54. 17 For 4 Against Married persons applying for home and community-based waivers should have the same spousal impoverishment protection as married nursing home applicants. When a married person enters a nursing home, the community spouse can keep up to $89,000 in joint assets, and the institutionalized spouse can retain $2,000. Married waiver applicants are only allowed $3,000 in joint assets (not counting the home).

55. 19 For 1 Against DHS should study the feasibility of a spend-down option for selected Medicaid programs, to enable applicants to "buy into" Medicaid when they exceed income limits.

56. 14 For 6 Against Medicaid reimbursement structure should mandate and fund minimum compensation levels for attendant care staff. The intent is that attendants share in rate increases, and that Medicaid take responsibility for funding wages and benefits that are adequate to hire and retain workers.

57. 15 For 5 Against Targeted case management is an important service to help people with disabilities arrange and monitor the services they need to live in the community. Current Medicaid reimbursement does not cover the cost of providing this service due to a low hourly rate and numerous exclusions. A new reimbursement system for targeted case management should be developed that is adequate to cover supervision, training, travel time, employee benefits, office expenses, etc.

58. 19 For 1 Against Improve Medicaid eligibility determination and response times by forming Quality Improvement teams of DHS employees and other stakeholders to recommend improvements. This is an issue for access and service delivery.

STAFFING RECOMMENDATIONS

GOALS FOR RECRUITMENT OF HEALTHCARE WORKERS

59. 20 For 0 Against Create a public education/awareness program to put the role of caregiver in the proper perspective. The job of caring for or assisting our loved ones to attain their full potential and participate in community life should be regarded as a worthwhile, quality profession and be compensated accordingly. Steps must be taken to stimulate this attitude adjustment. Ask for assistance from the Governor's office and DHS for a media campaign, including TV spots.

COLLABORATIONS WITH THE ARKANSAS WORKFORCE INVESTMENT BOARD

60. 17 For 2 Against. Policy makers need a coordinated, inter-agency system of data collection to estimate current, and project future, needs for direct care workers to evaluate existing data on the healthcare labor market.

61. 21 For 0 Against Create a direct care worker registry or "Caregiver Database" that will be accessible (By Internet, phone, or in County, City, and local Workforce Investment Centers) to both providers and consumers wishing to hire and direct their own personal care attendant.

A statewide registry of caregivers that is accessible on a website and in City, County and local Workforce Investment Center offices will help bring caregivers, who no longer work for many different reasons, back into the system and give them the option to work:

- In a different setting
- With a different client population, or
- On a different schedule with more or fewer hours.

62. 15 For 5 Against Develop a career ladder for health care workers with opportunities for career advancement. Create opportunities for skill building and access to better-paying jobs.

63. 12 For 8 Against Develop a system to rescue those caregivers who cannot meet their career goals due to lack of training, lack of funds, lack of aptitude or family obligations. Redirect them to a less challenging care giving role (e.g., attendant for a consumer who directs his own care or sitter for an elderly person).

64. 20 For 0 Against Distribute information on jobs in health care and opportunities for education at local Workforce Investment Centers.

65. 18 For 1 Against Encourage partnerships between local Workforce Investment Centers and industry heads and private training organizations.

66. 18 For 2 Against Explore collaborative efforts to develop the arworks.org website to match employees with employers (including consumers who wish to direct their own care).

EDUCATION OF HEALTHCARE WORKERS

67. 13 For 7 Against Create a database that lists all training centers and all employers in the State so that trainers can provide their graduates with local employment opportunities and employers can stimulate the recruitment of applicants with the promise of immediate employment.

68. 15 For 5 Against Create a statewide system of paraprofessional training centers using standardized curricula.

69. 18 For 1 Against Develop training curricula targeted for trainees with limited English language capabilities or literacy and numeric skills. Explore educational programs that connect recent immigrants to direct care employment, such as ESOL (English for Speakers of Other Languages) training. Current curricula also fail to address basic inter-personal communication and problem-solving skills.

70. 16 For 3 Against Create abbreviated packages of courses (educational modules) to allow caregivers to change jobs:

- Laterally (e.g., CNA in nursing home to psychiatric aide)
- Up (career ladder; e.g., CNA to LPN)
- Down (e.g., failure to pass exams shouldn't result in loss of a potential caregiver)

71. 12 For 6 Against Fund loan forgiveness and low-interest loan programs, scholarships and fellowships. Give health care employers priority access to workplace training funds from the Department of Labor, the Department of Education, the Department of Transitional Assistance, and the Workforce Training Fund of the Unemployment Compensation Fund.

72. 18 For 2 Against Promote innovative supervisory and management techniques.

RETENTION OF HEALTHCARE WORKERS

73. 14 For 5 Against Increase nurse and paraprofessional wage and benefit levels.

74. 14 For 5 Against Reward longevity with step increases in pay**.**

75. 12 For 6 Against Ensure wage parity across the health care sector.

76. 20 For 1 Against Examine the Medicaid reimbursement system for workers providing consumer-directed care. Ensure that wages are paid promptly and that contracting fees for paperwork are paid by DHS rather than subtracted from wages. Study ways to decrease data entry errors that result in delayed payments to workers.

77. 15 For 6 Against Provide health insurance for health care workers through:

- Sliding-scale Medicaid buy-ins for paraprofessionals;
- Pass-through health insurance coverage costs;
- State support for leveraging the collective purchasing power of health care employers with private insurers, and/or
- Access to public health insurance programs for children of eligible employees.

78. 14 For 7 Against Implement wage pass-throughs for direct-care workers that can be used only for wages and/or benefits. This would include full reimbursement for providers who pay higher shift differentials; weekend, holiday and overtime pay; sick leave and vacation time; and step increases for job tenure.

79. 20 For 0 Against Support provider consortia that, by joining together, can offer their employees full-time work and better benefits through pooled employee assistance and training programs. Ensuring full-time employment for direct-care workers will make them eligible for full Social Security benefits and employer group health insurance plans.

80. 17 For 2 Against Support caregiver associations to provide direct-care workers with peer support, educational opportunities and a sense of self worth.

81. 17 For 2 Against Create a welfare development fund for health care workers to provide targeted funding to overcome employment barriers and to support pre- and post-employment education. Investigate modifications in public supports to provide assistance with childcare, transportation, etc. Use Transitional Assistance to Needy Families' (TANF) funds to provide low-wage workers with expanded access to childcare and transportation.

82. 16 For 3 Against Evaluate the success rate of existing Welfare-to-Work Programs. Make recommendations to address multiple barriers to employment (e.g., substance abuse, physical or mental disabilities, limited resources for transportation and childcare).

<u>RECOMMENDATIONS TO CREATE A NEW POOL OF DIRECT-CARE WORKERS</u>

83. 15 For 4 Against Make long-term care the gateway to employment for new workers. Stimulate expansion of the qualified labor pool by providing targeted public supports for recent immigrants, people transitioning from welfare to work, and low-income individuals who need some kind of assistance to succeed.

84. 17 For 2 Against Get back all those caregivers who have left their profession by recruiting the professionals and paraprofessionals currently holding licenses, but not

practicing. Improvements in wages, benefits and working conditions may persuade this large potential pool of workers to return to careers in care giving.

Utilize the database of the Office of Long-term Care to contact certified nursing assistants (CNAs) who no longer work as CNAs. Contact the Board of Nursing for similar information on both registered (RNs) and licensed practical nurses (LPNs).

85. 19 For 0 Against Recruit nontraditional workers:

1. Older workers: Hire mature and disadvantaged workers in care giving jobs. Explore collaborative efforts with organizations like Green Thumb to provide training and placement of older and/or disadvantaged workers in care giving jobs. Now that there is no longer a penalty for individuals receiving Social Security who wish to continue working, there is a large pool of older workers for full- or part-time employment.
2. Workers with disabilities.
3. Part-time workers or workers willing to share jobs.

86. 19 For 0 Against Use the Ticket to Work and Incentives Improvement Act of 1999 to encourage people with disabilities to seek employment.

RECOMMENDATIONS TO SUPPORT FAMILY CAREGIVERS

87. 18 For 1 Against Request that CMS expand provisions for Medicaid payments to family members who provide care.

88. 16 For 3 Against Recognize aging and care giving as women's issues. Most caregivers are women and most older people are also women. Enlist the help of the Women's Project.

89. 18 For 2 Against Provide respite care for the caregiver. Encourage long-term care providers to explore day care and respite care options in existing facilities with low occupancy rates as part of a continuum of care. Examine the reimbursement systems for these services and streamline paperwork to make them more readily available to family caregivers and more financially attractive to providers.

CREATION OF A LONG-TERM CARE COMMISSION

90. 8 For 12 Against Create a legislature-sponsored, multi-stakeholder, consumer-driven Long-Term Care Commission to regulate all aspects of long-term care, both institutional and home- and community-based.

This Commission will incorporate both the Health Services Permit Agency (HSA) and the 9-member Health Services Permit Commission (which will cease to exist as a separate entity).

- The HSA will continue to generate projected bed need for institutional care, but expand its scope to include calculations of need for all the various supports and services in the community. This new responsibility is more consistent with the mission of this agency than is its current responsibility. (The mission and goals of the HSA are shown at the end of this document on page 7.)

- The HSC members would be absorbed into the membership of the larger Long-Term Care Commission.

The membership of the current Health Services Commission includes:

1. A representative of the Arkansas Health Care Association (representing nursing home owners)
2. A representative of the Residential Care Association
3. A representative of the Arkansas Hospital Association[1]
4. A representative of the Hospice Association
5. A representative of the Home Health Association
6. A person knowledgeable about business health insurance
7. A practicing physician[2]
8. A representative of the Department of Human Services
9. A representative of AARP[3]

Composition of the Commission:

1) A Commission Director, who shall be appointed by, and serve at the pleasure of, the Governor.
2) Legislators. (A member of the Senate, appointed by the President of the Senate and a member of the House of Representatives, appointed by the Speaker of the House.)[4]
3) Provider organizations:
   - Arkansas Association of Area Agencies on Aging
   - DDS Board
   - Developmental Disabilities Providers Association
   - The ARC of Arkansas
4) Consumers (senior citizens and people with disabilities):
   - A member of People First
   - A member of AARP
   - A member with a mental illness
5) Advocates representing the following groups:
   - AARP
   - ADAPT
   - Arkansas Disability Coalition
   - Association of HDC Parents
   - Autism Society
   - Disability Rights Center
   - Mental Health Council of Arkansas
   - NAMI-Arkansas
   - Partners for Inclusive Communities
   - The DD Council
   - The Independent Living Council

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[1] The individual currently serving is also a nursing home owner.

[2] This position is currently vacant. However, the physician previously occupying this position was also a nursing home owner.

[3] This individual is the only consumer on the board.

[4] We are awaiting input from Butch Reeves on how to word this section to involve legislators.

NOTE WELL: The number of individuals in 4) and 5) should be greater than the number of all representatives of provider organizations to ensure an equal voice for consumers.

6) The Directors of DHS-MS, DHS-AAS, DHS-DD, DHS-MH
7) A representative from Arkansas Rehabilitation Services
8) A representative from the Arkansas Workforce Investment Board
9) A representative from the Department of Education
10) A representative from the Department of Health
11) A representative from the Department of Labor
12) A representative from the Department of Workforce Education
13) A representative from the Disability Rights Center
14) A representative from the Employment Security Division
15) A representative from the Nursing Commission
16) A representative from the Social Security Administration (Disability Determination)

Roles of the Commission:

1. Evaluate the state's long-term care service delivery system and make recommendations to increase the availability and the use of non-institutional settings to provide care to the elderly and people with disabilities.
2. Analyze all legislation, rules, regulations, and methodologies for their impact on the entire continuum of care. All proposed bills, rules, regulations or methodologies dealing with any aspect of health care would be submitted to the Long-Term Care Commission for an analysis that would accompany the document when it goes to the legislature.
3. Ensure close communication and coordination among state agencies involved in developing and administering a more efficient and coordinated long-term care service delivery system in this state.
4. Develop strategies and write legislation to implement immediate reforms designed to:
    - Facilitate having the money follow the person, possibly through the use of health care vouchers.
    - Stimulate competition between health care providers based on quality of care.
5. Continually monitor budget issues and look for additional sources of funds, including federal and private grants.
6. Focus on providing services and supports for all populations of people with disabilities who are currently underserved due to:
    - Geographic location
    - Type of disability, or
    - Exclusion based on age or lack of funding (waivers or other funding streams)
    - Dual diagnosis (mental illness and developmental disability)
7. Develop a statewide plan to monitor health care consumption and worker availability.
8. Address all issues related to recruitment, education and retention of health care workers and recommend changes to address long-term direct care workforce needs over time.
9. Develop strategies to monitor the quality of home- and community-based services. Review current programs providing long-term care services to

determine whether the programs are cost effective, of high quality, and operating efficiently.
10. Review the Nurse Practice Act to assist the state in becoming more Olmstead compliant.
11. Collaborate with DHS on an ongoing public awareness program to educate consumers about home- and community-based services and supports and institutional alternatives.
12. Explore all avenues to distribute information to consumers about their long-term care options, using city, county, and local Workforce Center offices.

Mission and Purpose of the Health Services Permit Agency:

The Health Services Permit Agency, with direction from a nine member Health Services Permit Commission, is responsible for issuing Permits of Approval (POAs) for Nursing Homes, Residential Care Facilities, Assisted Living Facilities, Home Health and Hospice Agencies, Psychiatric Residential Care Facilities and Intermediate Care Facilities for the Mentally Retarded.

The Commission/Agency mission is to ensure appropriate distribution of health care providers through the regulation of new services, protection of quality care and negotiation of competing interests so that community needs are appropriately met without unnecessary duplication and expense.

Goals and Objectives:

1. Evaluate the availability and adequacy of health facilities and health services as they relate to long-term care facilities and home health care service agencies in Arkansas.
2. Designate those areas of the state and specify categories of health services, which are underserved or over served, and exempt certain underserved areas or categories of service from the permit of approval process.
3. Develop policies and adopt criteria for the review of applications and issuing of permits of approval.

PUBLIC AWARENESS RECOMMENDATIONS

91. 20 For 0 Against Develop DHS web *site listing consumer* services linked from its main site. It should be written for the lay person, be brief, concise, and *accessible to all individuals*. It should explain the implications of Olmstead in simple terms. This *site* should be linked from every DHS division web site and from the state's home page.

The web site should include all supports and services available to individuals with disabilities and their families. At a minimum, the site should include for each service: the name of service; type of individuals served; geographic area covered; eligibility criteria; and capacity. The site should include a self-assessment option for users. A comprehensive search engine for the site should be developed and maintained. Finally, the site should provide hyper links to national and regional service and information

providers. These objectives should be completed by July, 2003. However, some objectives, such as updating the database and maintenance will be ongoing.

92. 21 For 0 Against DHS needs to make the current DHS web site more user friendly. There should be more uniformity and consistency among the division web sites. A user-friendly version of the Arkansas Olmstead Plan should be accessible from every DHS web site as well as the state's home page, and the unexpurgated plan should be available as well.

93. 21 For 0 Against Other informational formats, corresponding with the improved web site (see numbers 1 and 2) should be available. These include a *service directory* and a toll-free phone referral system.

A. The *service directory* should follow, as closely as possible, the format of the web site. An informational tree *format* is recommended, though there should be no wrong "branch." In other words, a person can easily find what services he or she would be eligible for by referring to such a *directory*, without having to read the whole *directory*.
B. Similarly, the contact person at each DHS division should be able *use* the *directory* or web site as a template to refer the consumer to the appropriate area. This should reduce "run around" when consumers call by phone. (See Supports and Services recommendation on Single Point of Information.)
C. A brochure or informational card should be made available to the public that is easy to read and concise. It should list the various services and corresponding telephone numbers.

94. 17 For 2 Against DHS should develop a media relations package in a collaborative effort with the Public Awareness Committees of the Governor's Task Force on Supported Housing (GTFSH) and the Governor's Integrated Services Task Force (GIST).

95. 12 For 8 Against DHS should maintain a Public Awareness consumer advisory committee, comprised in majority of persons with disabilities and parents of children with disabilities.

96. 15 For 4 Against DHS should request that Legislative Research disseminate periodically informational bulletins to the legislators and assist them with constituent concerns.

SUPPORT AND SERVICES RECOMMENDATIONS

NURSING HOME

97. 17 For 3 Against Funding will follow the individual from setting to setting.

98. 18 For 2 Against Dispense with Permit of Approval process for nursing homes and assisted living facilities (let free enterprise determine need). TIMELINE: JULY 2003

99. 18 For 3 Against Require functional assessments of all public and private pay residents to nursing home placement.

COMPREHENSIVE CASE MANAGEMENT SYSTEM

100. 15 For 7 Against Develop a comprehensive case management system that is comprised of case managers who have received specialized training and certification that equip the case managers to prove case management across all services delivery systems. The case managers, available as an option, may serve as a single point of contact/entry into the multiple service systems. Case managers should present as many choices to clients as possible and should act in response to consumer* direction. (*consumer/family) TIMELINE: July 2004

101. 16 For 5 Against Design a standardized certification and training system (competency based, with levels) for comprehensive case managers. Curriculum topics will include at a minimum: natural supports, transportation, housing, access and eligibility and quality assurance.
TIMELINE: RFP ISSUED JANUARY 2003
CURRICULUM COMPLETED DECEMBER 2003

102. 14 For 5 Against Develop a media campaign to educate individuals about this new service. TIMELINE: JULY 2004

MEDICATION

103. 20 For 0 Against Include in the standardized resource directory (to be developed), a link to all pharmaceutical assistance programs.

104. 21 For 0 Against Review, and if necessary, legislatively, adopt a Nurse Delegation Act to allow more flexibility within the community-based care system. Review success in other states as a model for Arkansas (Ref. Oregon and Florida).
TIMELINE: REVIEW PROCESS BY OCTOBER 2002
IMPLEMENTATION BY JULY, 2003

105. 16 For 4 Against Medication access/reimbursement is tied to the individual, not the service setting. (Currently individuals can gain access to a greater number of medications in an institutional setting, then they can in the community.)

106. 13 For 6 Against All medications presently discarded by nursing homes should be used and made available to individuals regardless of their service setting.

REGIONAL COOPERATIVE

107. 13 For 8 Against Requests for Proposals (RFP's) should be issued (especially in rural areas) to begin the development of Regional Cooperatives to extend community-based services, such as: transportation, respite/crisis services, medication access, administrative resources, purchasing power and other needs. The purpose is to promote infrastructure development, where services are minimal or non-existent.

108. 19 For 1 Against Ultimately, the best outcome will be the development of a seamless delivery system of home, community and institutions. Staffs should become part of a common team focused on the client, rather than the system.

NATURAL SUPPORTS

109. 17 For 2 Against Increase community education on the topic of natural supports. Natural supports include non-paid individuals who form an informal network to assist individuals. The network may include; church members, neighbors, colleagues, friends, acquaintances, classmates, etc.

TRANSPORTATION

110. 21 For 0 Against The GIST should work with appropriate state agencies to develop and overall state plan for transportation that can reasonably accommodate people with disabilities, building upon existing transportation systems.

111. 20 For 1 Against Arkansas should examine and seek to address the need for transportation other than non-emergency medical care.

112. 21 For 0 Against Transportation programs should address the need for an aide or assistant for people who require extra assistance.

113. 20 For 0 Against Reimbursement methodologies should recognize the costs for training and testing drivers, aides, or both, to meet the needs of specialized groups who may require enhanced communications or physical transfer skills.

COLLABORATION

114. 19 For 0 Against Representatives from various groups that have been formed to come up with plans for the state for people with disabilities should meet to monitor the status of their plans. Some of those groups include: Supportive Housing Task Force, any active GIST Subcommittees and the Mental Health System Task Force.

QUALITY ASSURANCE

Continuing Quality Improvement is a critical piece of any service delivery system. We have defined Continuing Quality Improvement for services for people with disabilities as,

"A responsive feedback system that maximizes self direction and minimizes risk."

Any process considered should include four basic components:
1. A system of measurement and quality improvement activities for all populations (outcomes),
2. The availability of advocates, ombudsmen, or other individual representatives,
3. Established principles, expectations, and standards for all types of services,
4. An independent system of monitoring and evaluating services.

115. 14 For 4 Against It is our sole recommendation that the Governor form an ongoing commission to address Continuing Quality Improvement issues for all disabilities.

Appendix C

Waiver Services

While Arkansas can and will make improvements to its long term care system, the State has a strong record in giving consumers a choice of how and where they receive long term care outside institutions. Below is a brief description of DHS' four Home and Community Based Services (HCBS) that are funded through waivers from Medicaid.

Division of Aging and Adult Services

- **ElderChoices** is Arkansas' home and community based care waiver for the elderly, On any given day about 6,000 older Arkansans receive care in their homes through this nursing home diversion program.

- **Alternatives** is a second nursing home diversion program for younger individuals with physical disabilities.

- **IndependentChoices** is a form of consumer directed Personal Care. Arkansas was the first state in the nation to implement this Cash and counseling program.

Division of Developmental Disabilities Services

- **Alternative Community Services** is one of the fastest growing waiver programs for person with developmental disabilities in the nation and serves persons of any age.

Additional information on the Waivers:

Division of Aging and Adult Services Waiver Programs

ElderChoices is Arkansas' Medicaid home and community-based waiver designed for its elderly population. ElderChoices, implemented July 1, 1991, is designed for persons who due to physical, cognitive or medical reasons, require a level of assistance that would have to be provided in a nursing facility, if it were not for the services offered through this program. The program is designed to assist elderly persons reside in their own homes, or live with relatives or caregivers for as long as possible, if that is their choice.
ElderChoices has provided services to more than 13,000 elderly Arkansans since 1991.

The services offered through this program include:

 Homemaker - includes basic upkeep and management of the home and household assistance, such as laundry, essential shopping, errands, household tasks and meal preparation.

 Chore - provides heavy cleaning and/or yard and sidewalk maintenance in extreme circumstances, when lack of these services would make the home uninhabitable.

 Home Delivered Meals - Nutritious home-delivered meals provided to individuals who are homebound and unable to prepare their own meals.

 Personal Emergency Response System (PERS) - provides an in-home 24-hour electronic alarm system that enables an elderly homebound person to summon help in the event of an emergency.

 Adult Day Care - provides for a group program designed to provide care and supervision in a licensed adult day care facility.

 Adult Day Health Care - provides a continuing, organized program of rehabilitative, therapeutic and supportive health and social services and activities in addition to basic day care.

 Adult Foster Care - provides a family living environment for one or two clients who are functionally impaired and are considered to be at imminent risk of death or serious bodily harm and are not capable of living alone.

 Respite - provides temporary relief to persons providing long term care for clients in their homes. It may be provided in and/or outside of the client's home to meet an emergency need or as periodic scheduled relief from continuous care giving.

In addition to ElderChoices services, waiver recipients may receive other Medicaid covered services such as physician visits, some prescription drugs, personal care and others.

Alternatives

Alternatives is a Medicaid Waiver program that provides home and community-based services to a limited number of adults with physical disabilities.

Alternatives offers two consumer-directed services:

- *Attendant Care*: Assistance to accomplish tasks of daily living, based on need and approved by the physician. Based on need, the client may receive up to 8 hours a day, 7 days a week of attendant care. The client shall recruit, hire, supervise and approve payment of the attendant. Although the attendant may be a family member, it may NOT be a spouse or other legally responsible person.

- *Environmental Adaptations*: Modifications to the environment that increase independence or accessibility.

Who can apply?
Anyone who:

- Has a physical disability and income of no more than 300% of SSI

- Is between 21 and 64 years old

- Meets eligibility for Intermediate Level Nursing Home Placement
  Note: To be eligible for Intermediate level nursing home placement, the individual must require extensive assistance with 1 ADL or limited assistance with 2 ADLs (ADLs considered are transferring/locomotion, eating or toileting), or have a diagnosis of dementia, or have a medical condition that requires daily

monitoring by a medical professional. Individuals that required skilled care cannot be served.

- Has in-home service expenditures of no more than the cost of nursing home placement.

Independent Choices

The state of Arkansas offers a cash payment program called Independent-Choices, which substitutes a cash allowance for Medicaid services from provider agencies. People with disabilities are randomly assigned into two groups. The control group receives Medicaid personal care through a provider agency and the treatment group receives a monthly cash allowance and services to help them effectively use the allowance. Historical data indicates treatment group participants have less nursing home utilization than control group participants.

People age 18 and older eligible for Medicaid personal care can enroll in IndependentChoices at any time. People with cognitive impairments are also eligible. A person can choose a representative to administer the cash allowance on his or her behalf.

People in the treatment group have a lot of flexibility in how they use the cash allowance. Unlike people in the control group, these people can hire whomever they wish, including family and friends (other than spouses). Participants can also purchase items related to personal assistance, including assistive technology, appliances, and home modifications. Counseling/fiscal agencies, operating regionally, offer a wide variety of assistance to help people manage their cash allowance. To ensure the services are enough to meet participant needs and to monitor possible fraud or abuse, the counseling/fiscal agency contacts each person once a month and conducts an in-person reassessment every six months.

IndependentChoices required a Medicaid research and demonstration waiver authorized by Section 1115 of the Social Security Act. The waiver permits the state to disregard certain federal Medicaid rules such as providing cash to recipients. The project also negotiated with other federal agencies to ensure the cash allowance would not affect a participant's Social Security Income, food stamps, and other benefits.

Assisted Living (waiver pending)

The Assisted Living Federation of America defines **Assisted Living** as a special combination of housing, supportive services, personalized assistance and healthcare designed to respond to the individual needs of those who need help with activities of daily living. Supportive services are available, 24 hours a day, to meet scheduled and unscheduled needs, in a way that promotes maximum dignity and independence for each resident and involves the resident's family, neighbors and friends.

A Medicaid Assisted Living waiver is not yet in place in Arkansas, but the Robert Wood Johnson Foundation and NCB Development Corporation selected Arkansas as one of nine states to participate in the Coming Home Program. Coming Home seeks to develop affordable assisted living for low to moderate-income individuals.

The Coming Home program seeks to create models of assisted living that will serve low-income seniors including those on Medicaid, ie those with incomes of $545 per month. With that in mind, the goal of Coming Home projects is to reduce the shelter payment to about $350-$400 per month, with services funded through Medicaid.

The Arkansas Department of Human Services (ADH) has issued **Regulations for Assisted Living**. DHS promulgated the regulations in accordance with the Arkansas Administrative Review Process, which included a 30-day public comment period. To provide Assisted Living in Arkansas, one must:

- Obtain a Permit of Approval from the Arkansas Health Service Permit Agency, and

Obtain a License from the AR Department of Human Services Office of Long Term Care.

Developmental Disabilities Services Waiver Program

Alternative Community Services (ACS)

Current approved waiver services

Supportive Living Services are an array of individually tailored services and activities provided for eligible persons to enable them to reside successfully in their own homes, with their families, or in an alternate living residence or setting. These services fall into two general categories:

- **Residential Habilitation Supports** are designed to assist the person in acquiring, retaining or improving his/her skill in a wide variety of areas that directly affect his/her ability to reside as independently as possible in the community. These services provide the supervision necessary to live in the community. These supports, habilitative in nature, may address areas of need such as self-direction, money management, daily living skills, socialization, community integration, mobility, communication or behavior shaping, and management.
- **Residential Habilitation Reinforcement Supports** are supports that may be provided to an eligible person to reinforce therapeutic services, assist or supervise the person in performance of tasks such as meal preparation, shopping, etc. These services, however, cannot be performed separately from other waiver services. Companion and activities therapy services are included in this area of service and recognize the use of animals as a treatment modality to reinforce therapeutic goals.

Community Experiences Services are a flexible array of supports designed to allow persons to gain experience and abilities that will prevent institutionalization. Through this broad base of learning opportunities, eligible persons will identify, pursue and gain skills and abilities that reflect their interest. This model helps to improve community acceptance, employment opportunities and overall general well being

Respite Care provided under the ACS waiver fall into two distinct categories:

- **Respite Child Care Support Services** are services that promote access to and participation in child care through a combination of basic child care and support services for eligible children ages birth to 18 years. These services are to be provided only in the absence of the primary caregiver during those hours when the caregiver is at work, in job training or at school. Services may be provided in a variety of settings to include licensed day care, extended day programs, etc.

Participation fees are responsibility of parent. Waiver pays only for the support staff required due to developmental disability.

- Respite services may be provided for any eligible individual regardless of age on a short-term basis because of the need for relief of the unpaid primary caregiver.

Environmental Modifications are those adaptations to the eligible person's place of residence (structure) which are necessary to ensure the health, welfare and safety of the person or which enable him/her to function with greater independence within the home environment. Modifications may include widening of doorways, installation of ramps or grab bars, etc.

Adaptive equipment service provides for the purchase, leasing and, as necessary, repair of adaptive, therapeutic and augmentative equipment required to enable persons to increase, maintain or improve their functional capacity to perform daily life tasks that would not be possible otherwise.

Specialized medical needs allow for additional supply items to be covered as a waiver service when they are essential for home and community care. Examples of such items include disposable incontinence undergarments, nutritional supplements, etc. When such items are covered in the Medicaid State plan, this will be an extension of such services and can be accessed only after reaching state plan benefit limit with a prescription.

Supplemental Support services are designed to meet the needs of the person to improve or enable continuance of community living, to allow the opportunity to participate in integrated leisure, recreational, and social activities and make a positive difference in the life of the person. Supplemental supports may include emergency medical cost such as prescriptions drug co-pay, transitional expenses for initial integration into the community when transitioning from an ICF/MR or nursing home to the waiver etc.

Supported Employment services are designed for persons for whom competitive employment at or above the minimum wage is unlikely, or who, because of their disabilities, need intensive, ongoing support to perform in a competitive work setting. The employer is responsible for making reasonable accommodations in accordance with the American's with Disabilities Act. Reimbursement cannot be claimed if the person is not able to perform the essential functions of the job.

Consultation Services are services that assist persons, parents/guardians/responsible individuals, community living services providers and alternative living setting providers in carrying out the person's service plan. Consultation may include behavioral, nursing assessment etc.

Crisis Services-center based is 24 hour emergency care services for eligible persons with priority given to persons with a dual diagnosis. Admission is limited to persons in a crisis situation where current placement is no longer viable and immediate alternate placement cannot be identified.

Waiver Coordination services are provided to assure the delivery of all direct care services. This includes the coordination of all direct services care workers provided through the direct service provider, coordination of schedules for both waiver and

generic service categories and other activities necessary for appropriate service delivery in accordance with the plan of care.

Waiver Case Management is a system of ongoing monitoring of the provision of services included in the plan of care. Also included in this service are activities such as arranging for the provision of services and additional supports, facilitating intervention during crisis intervention, case planning, needs assessment and referral for resources, etc.

After amendments are promulgated, there will be three distinct service models available under the ACS Home and Community Based Waiver. They are:

- **Traditional Service Model**: Services are delivered through a DDS licensed and Medicaid enrolled service provider network with all service coordinated through a Case Management provider of the eligible person's choice.
- **Self-Determined Model**: Eligible persons needing Supported Living Services have the option of hiring and otherwise managing their direct caregivers.
- **Supported Living Arrangement Model**: Care is provided in DDS supported living arrangements in supported living apartments, follow along in-home and in group homes up to 15 beds